No. 83-2136

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT,
DEPARTMENT OF INCOME MAINTENANCE,
Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
AND THE UNITED STATES DEPARTMENT
OF HEALTH AND HUMAN SERVICES,
Respondents.

**On Writ Of Certiorari To
The United States Court Of Appeals
For The Second Circuit**

BRIEF FOR PETITIONER

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QUESTION PRESENTED

The Medicaid law, enacted in 1965 to provide federal financial support for medical assistance provided by states to needy people, does not cover services to patients under age 65 in an "institution for mental diseases" ("IMD"). A later amendment extended coverage to "intermediate care facilities" ("ICFs"), defined as institutions that serve people, without age limitation, requiring residential care for their mental or physical condition, but whose illness is not so severe as to require the greater degree of care furnished by a hospital or a skilled nursing facility. The question is whether the "IMD" limitation on coverage applies only to mental hospitals, or should be extended to ICFs that serve people requiring ICF-type care for their mental conditions.

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 731 F.2d 1052 and appears as Appendix A, pp. 1a-16a in the Appendix to the Petition for Certiorari ("Pet. App."). The opinion of the United States District Court for the District of Connecticut is reported at 557 F. Supp. 1077 and appears as Appendix C, pp. 1c-25c in the Appendix to the Petition for Certiorari. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services ("Department")[1] is unreported and appears as Appendix D, pp. 1d-61d in the Appendix to the Petition for Certiorari.

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[1] Throughout this Brief, we use the references "Department," "DHHS," or "DHEW" to refer to the Department of Health and Human Services or its predecessor, the Department of Health, Education, and Welfare.

JURISDICTION

The judgment of the Court of Appeals was entered on March 30, 1984. Pet. App. 1b. A Petition for a Writ of Certiorari was filed on June 28, 1984, and granted on October 29, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case involves the following sections of the Social Security Act: section 1905(a), 42 U.S.C. §1396d(a)(1), (4)(A), (14), (15) and (18)(B), which defines "medical assistance;" section 1905(c), 42 U.S.C. §1396d(c), which defines "intermediate care facilities;" and section 1902(a)(20) and (21), 42 U.S.C. §1396a(a)(20) and (21), containing the "Long Amendment" specifying certain requirements of state Medicaid plans. The

full text of these sections is set out in Appendix A to this Brief.

STATEMENT

The question presented -- whether the term "institution for mental diseases" ("IMD"), which is used in defining covered health care services (medical assistance) under the Medicaid program, was meant to cover only mental hospitals or embraces as well alternative facilities and settings for the care and treatment of the mentally ill, including intermediate care facilities ("ICFs") -- has been decided against DHHS by four federal courts, including the Court of Appeals for the Eighth Circuit (Pet. App. E), but was decided in favor of DHHS by the court below. Pet. App. A.

Underlying the legal question raised by this case are two broader issues: (1) whether the nation's poor or near-poor

who suffer from mental disabilities will have access to appropriate settings for care and treatment -- such as ICFs -- under the Medicaid law, and (2) whether federal financial support on which the states relied in developing health and welfare programs can be withdrawn after the fact based on legal interpretations not clearly established at the time the programs were undertaken. The resolution of these issues will have a profound effect on the continued viability of state mental health programs for needy people.

A. Pertinent Statutory and Regulatory Framework

The Medicaid program, established in 1965 by Title XIX of the Social Security Act ("the Act"), 42 U.S.C. §§1396 et seq., makes federal funds available to the states to share in the costs of medical care provided to needy individuals,

to the extent covered by an approved State Plan. Services provided to patients under age 65 in institutions for mental diseases ("IMDs") are excluded from federal financial participation. 42 U.S.C. §1396d(a)(18)(B). Services provided to persons 65 and over in IMDs are covered, but only on the condition that the state undertake programs to develop broader alternatives, including nursing homes, for dealing with the problems of the mentally ill. 42 U.S.C. §1396a(a)(20) and (21); S. Rep. No. 404, Pt. I, 89th Cong., 1st Sess. 145-46 (1965) (hereafter cited as "1965 S. Rep."). The term "institution for mental diseases" has never been defined in the statute; however, the statute does distinguish between IMDs, on the one hand, and alternative care settings, such as nursing facilities, on the other. 42 U.S.C. §1396a(a)(21).

In 1967, Congress first authorized federal assistance for intermediate care facility ("ICF") services as part of the programs of cash assistance for the aged, the blind, and the disabled. Pub. L. No. 90-248, §250, 81 Stat. 821, 920. In 1971, Congress repealed these provisions and brought ICF services under Medicaid. 42 U.S.C. §1396d(a)(14). An ICF was defined as an institution that provides medical assistance to individuals who because of their "mental or physical condition" require health care and services, but whose condition is not so severe as to require the degree of care that a hospital or skilled nursing facility provide. 42 U.S.C. §1396d(c).

Shortly after enactment of the Medicaid law, the Department adopted interpretive regulations that defined an IMD eligible for federal funding with respect

to persons aged 65 and over to mean a psychiatric hospital that met prescribed standards. No other category of residential facility was referred to. Handbook of Public Assistance Administration, Supplement D (hereafter cited as "Handbook"), §D-5141.14(d). The Handbook also restated the statutory bar to coverage of any person under 65 who

> "is a patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed)." Handbook, §D-4620.2.

Despite codification and periodic reorganization of the regulations, the substance of these provisions has not changed materially since their first adoption.[2]

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[2] The present provisions appear in 42 C.F.R. §§435.1009 and 440.140 (1983).

The issue of extending the IMD exception to nursing homes (skilled nursing facilities and intermediate care facilities) first surfaced in a series of internal memoranda from the Central Office staff to regional officials of DHEW in 1975 and 1976.[3] After a delay of several years, the Department dispatched audit teams to investigate a number of states to determine whether certain nursing facilities that had been participating in the Medicaid program should be classified as IMDs.

B. The Current Dispute

Since October 1974, Connecticut has provided for coverage of ICF services in its Medicaid Plan. Middletown Haven Rest Home, a 180-bed ICF, began operating as a

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[3] Field Staff Information and Instruction Series, FY 76-44, FY 76-97, and FY 76-156. Joint Appendix ("J.A.") 1d-11d.

duly certified Medicaid provider in 1977.[4] From 1977 to 1980, Connecticut received federal funds under the Medicaid program for services provided to eligible residents of Middletown Haven. Pet. App. 4a. The residents of Middletown Haven suffered from a variety of problems, both physical and mental. The facility was equipped to care for residents with mental conditions, although it did not admit patients with acute mental disorders. J.A. 43a. Middletown Haven residents were admitted from a variety of sources,

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[4] Connecticut's ICFs are administered by the Department of Income Maintenance. Connecticut also has four state-run mental hospitals and eight accredited private psychiatric hospitals whose function is the care and treatment of mental illness. These institutions, which are concededly IMDs, are under the jurisdiction of the Connecticut Department of Mental Health and do not receive Medicaid funds for services provided to individuals under age 65. J.A. 2b.

including three state mental hospitals. J.A. 17a.[5]

Federal officials began their investigation of Connecticut's nursing homes in May 1979. In December 1979, an audit was conducted of patient records at Middletown Haven Rest Home. A report issued in May 1980 found that most of the residents at Middletown Haven had mental diagnoses of some sort, and concluded that Middletown Haven should be classified as an IMD. J.A. 2a-25a. Acting on that report, the Department issued a notice of disallowance to Connecticut in September 1980, in the amount of $1,645,655, representing all of the federal funds paid to the state for the care of residents at Middletown Haven for the period

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[5] Since the disallowance action under review, Connecticut has not sought federal Medicaid funds for care provided at Middletown Haven.

January 1, 1977, through September 30, 1979. J.A. 1e-6e.[6]

The disallowance was not predicated in any way on the quality of services provided to residents at Middletown Haven. To the contrary, DHHS officials responsible for the audit rated Middletown Haven highly and described it as an "excellent facility" and an "ideal ICF." J.A. 11c, 19c.

Connecticut's request for administrative review of the disallowance was consolidated with similar requests of

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[6] Classification of a facility as an IMD has the effect of precluding financial support for the care of any resident under age 65, whether or not the particular resident suffers from a mental disability. The disallowance in this case applied to all residents of Middletown Haven, although not all were found to have a mental diagnosis. J.A. 17a. Because the Connecticut Medicaid Plan did not opt for coverage of ICF services provided in an IMD, the disallowance was also applied to funds used to support services to residents of Middletown Haven aged 65 and older. J.A. 24a.

Illinois, Minnesota and California by the Departmental Grant Appeals Board ("Board"), a body within DHHS established by the Secretary to resolve disallowance disputes. The Board upheld the disallowances against all four states. Pet., App. D.[7] The Board's decision was appealed separately by each of the affected states. Minnesota prevailed in the District Court[8] and the Eighth Circuit Court of Appeals.[9] Pet., App. E. Illinois

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[7] The disallowance amounts against the other states were $4,261,162 for Illinois, $2,329,401 for California, and $896,159 for Minnesota. Pet. App. 49d, 53d, 61d. Since these initial cases, the Department has asserted disallowances against other states on the same ground, and if its position is sustained here it can be expected to assert disallowances against these and other states with respect to services previously furnished by providers other than those covered by the initial disallowances.

[8] Minnesota v. Schweiker, No. 4-82-155 (D. Minn. August 25, 1982).

[9] Minnesota v. Heckler, 718 F.2d 852 (8th Cir. 1983).

prevailed in the District Court.[10] Pet., App. F.[11]

In this case the District Court granted summary judgment to Connecticut, holding that the different level of care provided to patients in an ICF such as Middletown Haven, as opposed to the level of care expected in a mental hospital, precluded classification of Middletown Haven as an IMD. Pet., App. C.[12] The Second Circuit Court reversed, based upon its conclusion that the term "institution for mental diseases" in the Medicaid

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[10] Illinois v. United States Department of Health and Human Services, No. 82-C-1349 (N.D. Ill. June 30, 1984) (appeal pending).

[11] No decision has yet been rendered in the district court suit brought by California to challenge its disallowance.

[12] Jurisdiction to review the disallowance action lay in the District Court under 28 U.S.C. §1331 (1982), pursuant to a cause of action conferred by 5 U.S.C. §704 (1976), and is not contested by the Department. See Pet. App. 7a, 2c-3c.

statute was meant to embrace ICFs and skilled nursing facilities ("SNFs") as well as mental hospitals. Pet., App. A. This is the decision that Connecticut asks this Court to review and overturn.

SUMMARY OF ARGUMENT

I.

The term "institution for mental diseases" ("IMD") as used in the Medicaid law does not encompass nursing facilities, but is confined to mental hospitals. While the term IMD is not defined, the statute does provide that those states electing to cover persons aged 65 and over in IMDs must undertake to develop comprehensive plans for the care of the mentally ill, including establishment of "alternatives" to public institutions for mental diseases," among which "nursing facilities" are specifically listed. 42 U.S.C. §1396a(a)(20) and (21) (the

"Long Amendment"). This provision demonstrates that Congress did not intend the term IMD to include nursing facilities.

Congressional intent to extend Medicaid to intermediate care facilities ("ICFs") (a class of nursing facilities) that serve the mentally ill is shown by the statutory definition of an ICF as an institution providing health care for people with "a mental or physical condition" requiring ICF-level care. 42 U.S.C. §1396d(c). There was no age limit on Medicaid support for care of a mental condition in an ICF.

The interpretation of the term IMD as confined to mental hospitals is powerfully supported by a long legislative record. The term was first used in 1950 to exclude residents of mental hospitals from federally-supported public assistance, since states had traditionally

borne responsibility for those institutions. Thereafter, the term IMD was repeatedly and consistently used as a synonym for mental hospitals. The history of the 1965 law which incorporated the term into Medicaid shows a well-expressed intent to encourage the states to deemphasize reliance on public mental hospitals, the size and nature of which were regarded as inimical to successful treatment of most mental patients, and to develop alternative approaches for treating mental illness. The term IMD was used throughout to refer to mental hospitals in contrast to the alternative kinds of facilities that were to be encouraged, such as nursing facilities. Subsequent legislative history, in connection with the amendments that brought ICFs under the Social Security Act and then into the

Medicaid program, confirm this limited understanding of the term IMD.

The Department regulations, explanatory documents and public statements in the several years following enactment of Medicaid all evidence the understanding of the IMD term as confined to mental hospitals and not extending to nursing facilities. This Court so understood the term when it decided Schweiker v. Wilson, 450 U.S. 221 (1981) and other courts have consistently read the term in the same way.

The Department's change of interpretation, evidenced by internal memoranda prepared in 1975 and 1976, is not faithful to the terms of the statute nor to the decades of history that show that Congress used the term IMD to mean only mental hospitals. Since Middletown Haven was an ICF and was neither a mental

hospital nor did it manifest the undesirable characteristics that caused Congress to limit federal support for mental hospital care under Medicaid, it was wrong to withdraw federal Medicaid funds for Middletown Haven on the ground that it was an IMD.

II.

The disallowance of federal funding for Middletown Haven represents after-the-fact imposition of conditions to federal grant funds not knowingly accepted by Connecticut, and thus constitutes an impermissible use of the constitutional spending power. For this additional reason, the disallowance cannot be sustained.

The disallowance was after the fact because the Department never gave states reasonably reliable notice that the IMD exception would be applied to ICFs, or

how it would be determined that an ICF was an IMD. Not until the Department's audit, which was based on unspecific criteria of dubious validity, could Connecticut know that Middletown Haven would be classified as an IMD.

Medicaid represents an exercise in "cooperative federalism" (Harris v. McRae, 448 U.S. 297 (1980)), establishing a relationship between state and federal governments "in the nature of a contract." Pennhurst State School v. Halderman, 451 U.S. 1 (1981). While the federal government surely retains the right, pursuant to its spending power, to impose conditions on grants of Medicaid funds to states, any such imposition must be unambiguous, so that states know in advance the terms on which they may receive federal support. Id. at 17. Any

other approach threatens havoc to state fiscal management.

Application of the IMD exception to deny funding for Middletown Haven after those funds were received and expended by Connecticut violates the Pennhurst principles.

III.

No deference is due the Department's interpretation of the IMD exception because that interpretation is so contrary to the terms, meaning and purpose of the Medicaid law. Security Industry Association v. Board of Governors, 82 L.Ed.2d 107, 113 (1984). Deference is especially unwarranted in view of the Department's change of position and its failure to articulate and implement its new position in a manner that would permit its reasonable application by states. Deference is also unwarranted because the new federal

interpretation is based on a policy concern for inappropriate placement of people in ICFs that Congress considered and resolved by other means not involving a blanket prohibition on Medicaid participation for ICFs specializing in the care of mental cases.

ARGUMENT

This Court has commented on the nature of the unique relationship between the state and federal governments under the Social Security Act in cases involving private challenges to aspects of state public assistance programs. See King v. Smith, 392 U.S. 309 (1968); Rosado v. Wyman, 397 U.S. 397 (1970); Dandridge v. Williams, 397 U.S. 471 (1970); and Harris v. McRae, 448 U.S. 297 (1980). However, this case is important because it is the first case to reach the Court involving a dispute between the

federal and state governments under the Act. Apart from its bearing on federal-state relations, this case will also have an important impact on the treatment of mental illness in America. The 20th century has been marked by an "expanding concern of society with problems of mental disorders" (Addington v. Texas, 441 U.S. 418, 426 (1979)) and has seen great progress in public and scientific understanding of mental disability and in the discovery of new resources and techniques for treating mental illness. Congress, especially in the last thirty years, has taken a leadership role in the pursuit of more progressive treatment of the mentally ill. But the position maintained in this case by the federal agency undermines the progressive legislative steps of the past three decades.

I. A BRIEF RESUME OF THE EVOLUTION OF FEDERAL POLICY ON THE PROBLEMS OF MENTAL ILLNESS.

A. Development and Nature of State Mental Hospitals.

The mentally ill have not always been treated with compassion and care. Through most of recorded history, they have been the objects of abuse or vilification. In the nation's earliest days the mentally ill, if not exiled, were confined in jails, almshouses or poorhouses. Acceptance of more humane policies came slowly. The first public asylum for the mentally ill was erected in Williamsburg, Virginia in 1773, but several decades passed before another such facility was opened.

There were movements to improve the care of the mentally ill in America during the 19th century. One reformer of particular fame was the legendary Boston

schoolteacher, Dorothea Dix, whose crusade to improve the lot of the incarcerated mentally ill led to the establishment or enlargement of mental hospitals by many states.[13]

State mental hospitals increased rapidly after the Civil War, although the number of available beds was never sufficient to meet the need, and most facilities quickly became overcrowded. Moreover, the ideal of the mental hospital as a place of treatment and cure of all forms of mental disease was quickly dashed, in part by the shortcomings of knowledge and treatment capability, and

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[13] Ms. Dix' efforts at the federal level were less successful. Although she helped to persuade the Congress in 1854 to grant federal lands to finance the construction of state hospitals for the insane, President Pierce vetoed the bill on the ground that the federal government had no business in the field of mental health, or any other aspect of public welfare. VII Messages and Papers of the Presidents 2780-89 (1914 ed.).

the institutions became predominantly custodial in nature.[14]

An important development in the late 19th century was the assumption of financial responsibility by the State of New York for the care of its mentally ill, and in the ensuing decades most states followed this lead. Further construction of new state facilities occurred throughout the first half of this century. Yet there was only limited progress in the treatment provided to the institutionalized mentally ill. In the best of facilities, care remained essentially custodial, and substandard or inhumane

[14] David Rothman, in his book "The Discovery of the Asylum," documents the decline of mental hospitals "from a reform to a custodial operation" (p. 265), leading to the "personal revulsion" (p. 295) that was a common reaction to state mental hospitals in the mid-20th century.

conditions abounded.[15] Mental hospitals were widely perceived as permanent places of confinement for those with mental ailments for which no cure or treatment was known. See O'Connor v. Donaldson, 422 U.S. 563, 583 (1975) (Burger, C.J. concurring). By mid-century, the typical public mental hospital housed several thousand patients.[16]

B. Establishing the Basis For Federal Policy.

While there were forays into the mental health field by the Army Department

[15] Mary J. Ward's gripping account in "The Snake Pit" riveted public attention after World War II on the deplorable conditions inside many large public mental hospitals.

[16] On the history of the care of mentally ill, see generally A. Deutsch, The Mentally Ill in America (2d ed. 1947); D. Rothman, The Discovery of the Asylum (1971); R. Connery, The Politics of Mental Health (1968); S. Brakel & R. Rock, The Mentally Disabled and the Law (rev. ed. 1971). See also R. Rock, Hospitalization and Discharge of the Mentally Ill 69-72 (1968).

(Deutsch, supra, at 464-469) the first federal commitment to deal systematically with mental health came with the passage of the National Mental Health Act of 1946. Pub. L. No. 79-487, 60 Stat. 421. The Senate report recommending this Act noted that "[m]ental hospitals provide care principally for the most seriously ill; yet our mental hospitals are today poorly equipped to serve even the limited function of treatment after the illness of patients has become disabling ...." The report referred to abusive conditions in a number of institutions. S. Rep. No. 1353, 79th Cong., 2d Sess. (1946), reprinted in 1946 U.S. Code Cong. & Ad. News 1259, 1261-2.

The 1946 Act established the National Institute of Mental Health within the Public Health Service, and authorized aid to states for the development of mental

health services. The work begun as a result of the 1946 Act brought recognition of the need for a more enlightened approach to dealing with mental illness. Accordingly, Congress enacted the Mental Health Study Act of 1955. Pub. L. No. 84-182, 69 Stat. 381. This joint resolution observed that the increasing burden of coping with the problems of mental illness "may well be due primarily to an outmoded reliance on simple custodial care in mental hospitals as the chief method of dealing with mental illness." The Act called for a study under the auspices of the Surgeon General into the resources and means for dealing with the mentally ill. The aims were ambitious: to prepare a blueprint for replacing the then-current system, characterized predominantly by custodial care in gigantic remote mental institutions, with

new modern means for treating and rehabilitating mental disabilities. See S. Rep. No. 870, 84th Cong., 1st Sess. (1955), reprinted in 1955 U.S. Code Cong. & Ad. News 2530.

Five years later, the Joint Commission on Mental Illness and Health, which had been established under the 1955 statute, issued its final report entitled "Action for Mental Health."[17] The Commission recommended, among other things, that no more state hospitals of more than 1,000 beds be built, that no patient be added to any existing hospital already housing 1,000 or more patients, and that large state hospitals gradually be limited

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[17] Joint Commission on Mental Illness and Health, Action for Mental Health (1961) (hereafter cited as "Jt. C. Rep. ___").

to the most severe cases of mental illness. Jt. C. Rep. at xvi, 289-90.[18]

The Commission urged greater attention to aftercare and intermediate care as essential components of the service provided to mental patients, such components to include, among other things, nursing homes. The general unavailability of nursing homes qualified and willing to care for disturbed patients and meet their rehabilitative needs was noted, and the need for improvement stressed. Id. at 178-84. It was urged that public expenditures for mental health services be expanded, with the federal government to

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[18] The Commission's report, quoting earlier surveys, described state mental hospitals as "dumping grounds" for people with a variety of problems that were difficult to treat. The presence of these socially undesirable persons combined with many elderly and chronic patients seemed conducive to the "custodial and apathetic atmosphere that is a striking feature of our state hospitals, including the better ones." Id. at 175.

share substantially in the increased costs. Id. at xvii, xx, 178-84, 270-71, 286-87.

The Joint Commission Report sparked renewed attention to how governmental action could help to solve the problems identified.[19] One outcome of this renewed interest was enactment of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282.[20]

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[19] See Connery, supra, at 42; 1 Public Papers of the Presidents: Administration of John F. Kennedy, No. 492, 767 (1961); 108 Cong. Rec. 7849-50 (1962); H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1063; Hearings on Social Security Amendments of 1971 Before the Senate Committee on Finance, 92d Cong., 1st and 2d Sess. 934 (1972) (hereafter cited as "1971-72 Senate Hgs.).

[20] The House report on this bill described the poor condition of state mental hospitals throughout the nation. Almost 20 percent were found to be fire and health hazards by the standards of their own states. "Only a small percentage of the institutions can be said to be therapeutic

(footnote cont'd)

Even before this, the question of federal assistance in caring for the mentally ill had been addressed in the context of the Social Security Act, and it was an important issue in the debate over a federal role in financing health care that led to the adoption in 1965 of the Medicare and Medicaid programs.

C. Origins of the IMD Provision in the Social Security Act.

The public assistance programs for the elderly (Title I) and the blind (Title X), contained in the Social Security Act of 1935, covered needy people residing in private institutions. However, residents of public institutions of all kinds were

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(footnote cont'd)
and not merely custodial." Professional staff inadequacies were widespread. These 278 state hospitals collectively housed over one-half million patients -- an average of almost 2000 patients per institution. H.R. Rep. No. 694, 88th Cong., 1st Sess. (1963), reprinted in 1963 U.S. Code Cong. & Ad. News 1064.

excluded on the theory that the states had assumed responsibility for their maintenance. Act of Aug. 14, 1935, §§3, 1003, 49 Stat. 620, 621, 646; see 1965 S. Rep. 144.

The Act was expanded in 1950 to incorporate aid to the permanently disabled (by reason of physical or mental impairment) and to permit direct payment for medical care as well as for subsistence needs. At the same time, the coverage provisions were modified to permit assistance to some residents of public medical institutions, but to exclude assistance for patients in both public and private institutions for tuberculosis or mental diseases. Pub. L. No. 81-734, §§ 303, 343, 351, 64 Stat. 549, 554,

557-58.[21]

This was the first use in the law of the term "institution for mental diseases." The new provision originated in a study by a panel of distinguished citizens, known as the Advisory Council on Social Security, established pursuant to Senate Resolution No. 141, 80th Cong., 1st Sess. (1947). The Council's report (Senate Document No. 208, 80th Cong., 2d Sess. (1949)) became the foundation for the 1950 amendments. Even on this first occasion, it was evident that the exclusion was intended to refer to mental hospitals. Though aware of the limits of the original Social Security Act, the Council thought that "the Federal Govern-

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[21] Patients in medical institutions (general hospitals) who were diagnosed as tuberculosis or psychosis cases were also excluded from coverage. Id.

ment should participate in payments made to or for the care of old-age-assistance recipients living in public medical institutions other than mental hospitals." Id. at 114 (emphasis added).[22] The Advisory Council pointed to a substantial number of elderly people living in nursing homes. Id. at 115.[23] Its recommendation for expanding coverage to institutionalized persons encompassed them (id. at 116), which further shows that

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[22] The exclusion of mental hospitals from coverage of the old-age assistance program was understandable. Consideration of the National Mental Health Act in 1946 had emphasized the enormous number of people -- close to one-half million -- in state mental hospitals. States had traditionally borne the cost burden of those facilities, and there was no impetus to shift part of that large bill for caring for the elderly poor to the federal treasury.

[23] The Advisory Council recommended the establishment of standards for nursing homes whose residents were to be covered, and this recommendation was also accepted. Pub. L. No. 81-734, §301(b), 64 Stat. 548; S. Rep. No. 1669, 81st Cong., 2d Sess. 58-9 (1950).

the IMD exception applied only to mental hospitals.[24]

An effort was made to eliminate the IMD exception in 1960. In that year Title I was augmented by a program of medical assistance to the aged.[25] The bill as reported contained an IMD exception, described in the reports as an exclusion for "services rendered in mental ... hospitals." S. Rep. No. 1856, 86th Cong., 2d Sess. 7, 111 (1960); H.R. Rep. No. 1799, 86th Cong., 2d Sess. 7, 133-34

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[24] The House Committee on Ways and Means, which initiated the bill that became law in 1950, relied upon the recommendations of the Advisory Council, and its discussion of the amendments relating to institutionalized persons followed closely the discussion in the Advisory Council's report. See H.R. Rep. No. 1300, 81st Cong., 1st Sess. 5, 42, 152 (1949). The Senate Finance Committee adopted the House view. S. Rep. No. 1669, 81st Cong., 2d Sess. 58, 175 (1950).

[25] This new program covered those whose income was not so low as to qualify them for cash assistance. Pub. L. No. 86-778, §601, 74 Stat. 991.

(1960). An amendment to eliminate the IMD exclusion was adopted by the Senate, although there was substantial dissent because of the high cost of assuming responsibility for the care of the elderly in mental hospitals. 106 Cong. Rec. 16001-16006 (1960). The amendment was dropped in conference. H.R. Rep. No. 2165, 86th Cong., 2d Sess. 27 (1960).[26]

Thus, by the time of passage of the Medicaid law in 1965, there had been considerable attention devoted to the problem of mental illness. The Joint Commission had strongly recommended steps to deemphasize reliance on large, essentially custodial mental hospitals, and

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[26] The 1960 legislation did modify the prohibition on coverage of psychotics and tuberculars in general hospitals (note 21, page 35, supra) by permitting federal support for the first seven weeks of their hospitalization. Pub. L. No. 86-778, §601(a), 74 Stat. 991.

had stressed the need for alternative approaches, including intermediate facilities like nursing homes. Congress had twice determined to exclude coverage of the needy elderly, blind and disabled in institutions for mental diseases because of a disinclination to assume the large cost burden for mental hospital care that had been borne by the states. There was not the slightest indication that the IMD exclusion covered any facility other than a mental hospital.

D. Expansion of Support for Care of the Mentally Ill Under Medicaid -- The Long Amendment.

National health care financing proposals were advanced continuously since Franklin D. Roosevelt became President but provoked great controversy and were

never adopted.[27] But by 1965 the tide had turned. As President Johnson relates, the dramatic turning point came in a session of the Ways and Means Committee on March 2, 1965, when Chairman Mills agreed to support not only health insurance for the elderly (Medicare) but also expanded medical assistance for the needy (Medicaid), modeled on the medical assistance program for the elderly adopted in 1960.[28]

The Ways and Means Committee announcement of the results of its historic session, in summarizing the new Medicaid program, advised that

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[27] See, e.g., W. Cohen, "The Development of the Social Security Act of 1935: Reflections Some Fifty Years Later," 68 Minn. L. Rev. 379, 383-87 (1983); K. Davis, "The Birth of Social Security," 30 American Heritage 38 (April/May 1979); H. Truman, Years of Trial and Hope 19-23 (1956); 108 Cong. Rec. 14628, 19130 (1962).

[28] L. Johnson, The Vantage Point 214-16 (1971).

> "present limitations on Federal participation in public assistance to aged individuals in tuberculosis or <u>mental disease hospitals</u> would be removed under certain conditions." House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Decisions by Committee on Health Insurance, etc. 1 (Comm. Print 1965) (emphasis added).

The conditions were also summarized in the release. The Committee's proposal required

> "as a condition of Federal participation in such payments to, or for, mental patients certain agreements and arrangements to assure that better care results from the additional Federal money." <u>Id</u>. at 15.

Together with the community mental health center legislation enacted two years earlier, these provisions, which were adopted by both houses as part of the Medicaid law (42 U.S.C. §1396a(a)(20) and (21)), formed the foundation for a transformation of care of the mentally ill, as urged by the Joint Commission on

Mental Illness and Health.[29] In the ensuing two decades there has been a major shift in the settings in which mentally disturbed people are treated -- away from large, remote mental hospitals and toward nursing homes, clinics and other community-based facilities.[30] At the same time, in significant measure custodial care has been displaced by treatment in accordance with individually-developed plans that bring the great advances in the knowledge about causes and cures of mental illness to bear on the hundreds of

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[29] The new provisions were also incorporated into Title I (aid to the aged). In addition, the 1965 law deleted provisions in all titles limiting the extent of coverage available to psychosis and tuberculosis cases in general hospitals. See 1965 S. Rep. 144, 216-17.

[30] Between 1960 and 1980 the occupancy of public mental hospitals dropped from 536,000 to 140,000 patients. 1 Historical Statistics of the United States (1975 ed.), p. 84; Statistical Abstract of the United States, 1982-83, pp. 112, 118.

thousands of citizens afflicted with mental disabilities.[31]

This was the purpose of the provisions that were summarized in the Ways and Means Committee release, and which are known as the "Long Amendment" because they were first put forward by Senator Long and adopted by the Senate during its consideration of Social Security Act amendments in 1964. 110 Cong. Rec. 21346-49 (1964). As the <u>quid pro quo</u> for federal support for the elderly in mental hospitals, the states had to undertake to improve the means of care and treatment of mentally ill citizens, through establishment of joint working relationships

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[31] See, e.g., Hearings on Social Security Amendments of 1967 Before the Senate Committee on Finance, Part 1, 90th Cong., 1st Sess. 400-04 (1967). The number of professional staff per patient in public mental hospitals more than quadrupled between 1960 and 1980. See statistical sources, note 30, page 42, supra.

between welfare agencies and mental health authorities, and by insuring individual plans of care for institutionalized patients that were periodically reviewed and revised, affording appropriate treatment within the institution, and taking steps to develop alternatives to mental hospital care for the mentally ill. 42 U.S.C. §1396a(a)(20).[32]

This last condition was especially important. Under the Long Amendment, in order to receive federal support for care

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[32] These provisions applied if a state Medicaid plan covered the elderly in either public or private IMDs. But the focus of attention throughout consideration of the issue was on public mental hospitals, which housed the overwhelming number of affected patients, and whose characteristics had been so forcefully brought forward by the report of the Joint Commission and in other well-publicized accounts. The number of patients in private mental hospitals remained between 13,000 and 14,000 nationwide between 1960 and 1980. See statistical sources, note 30, page 42, supra.

of the elderly in public mental hospitals, it was required that the state show

> "satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." 42 U.S.C. §1396a(a)(21).

This theme was stressed in the extensive discussion of the Long Amendment in the Committee reports, both of which identified "nursing homes" as among the alternatives to mental hospitals that were to be encouraged. 1965 S. Rep. 144-47; H.R. Rep. No. 213, 89th Cong., 1st Sess. 126-29 (1965) (hereafter cited as "1965 H. Rep.").[33]

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[33] The Committees in this respect were following the recommendation of President Johnson, whose message submitting health legislation in 1965 referred to the emerging "new era in the prevention, treatment and care of mental illness" and admonished that "mere custodial care of patients in large, isolated asylums is clearly no longer

(footnote cont'd)

E. Extension of the Social Security Act To Cover Intermediate Care Facilities.

Although Medicaid was a great advance in meeting the health needs of the indigent, there were gaps in its coverage. One such gap related to persons with less severe disabilities who required residential care but of a less intensive and confining nature than was typical of hospitals or skilled nursing facilities. To deal with this situation, Congress added a new Title XI to the Social Security Act in 1967, authorizing federal support for payment for services to aged, blind or disabled people eligible to participate in the cash assistance programs who resided in intermediate care facilities. An ICF had to provide more

(footnote cont'd)
appropriate." H.R. Doc. No. 44, 89th Cong., 1st Sess. 5 (1965).

than mere room and board care, although less than is required for a skilled nursing home. The new law covered people in ICFs "because of their physical or mental condition." Pub. L. No. 90-248, §250, 81 Stat. 920 (1968).[34] The law was designed to allow States to move substantial numbers of welfare recipients from skilled nursing homes (which were covered by Medicaid) to lower cost institutions. S. Rep. No. 744, 90th Cong., 1st Sess. 29, 188-89 (1967).

In 1971, the authorization for federal support of ICF care was transferred to the Medicaid title, thereby extending coverage to the near poor as well as those who were eligible for cash assistance under the adult assistance programs.

[34] Although the law was entitled "Social Security Amendments of 1967," it was not signed by the President until January 2, 1968.

Pub. L. No. 92-223, §4, 85 Stat. 809. The basic definition of ICF was carried over from the 1967 legislation.[35] 42 U.S.C. §1396d(c).[36]

The incorporation of ICFs into the Act was critical to achieving the objectives of the Long Amendment of encouraging alternatives to mental hospitals for the care of the mentally ill. ICF care has expanded significantly since it was brought under the Social Security Act,

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[35] A provision was added that an ICF did not include, for persons under age 65, a public institution for mental diseases or mental defects, "except as provided in subsection (d)." The latter defined mental retardation facilities eligible for Medicaid coverage. This added provision grew out of debates over the extent of coverage of public mental retardation institutions. See note 43, pages 59-60, infra.

[36] A further broadening of federal support for the care and treatment of mental patients occurred in 1972 when Medicaid coverage was extended to children in mental hospitals under specified conditions that would assure active psychiatric treatment of their mental problems. Pub. L. No. 92-603, §299B, 86 Stat. 1460.

reflecting the substantial need throughout the nation for ICF-level care of people with either physical or mental conditions (or both) that prevent them from living independently.[37]

II. MIDDLETOWN HAVEN QUALIFIED AS A MEDICAID PROVIDER UNDER THE STATUTE.

A. Medicaid Covers ICFs Treating People Whose Mental Condition Creates Their Need For Care.

Section 1905(c) of the Act (42 U.S.C. §1396d(c)) defines an ICF as an institution that provides health-related care and services to individuals who "because of their mental or physical condition" require care and services, above the level of mere room and board, that can only be provided in an institutional

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[37] By the end of 1979 there were over 10,000 certified ICFs participating in the Medicaid program, in addition to over 7,000 skilled nursing facilities. The Medicare and Medicaid Data Book, 1981 at 122 (DHHS, April 1982).

setting. The statute requires that the ICF meet service and safety standards established by DHHS.

Between 1977 and 1979, Middletown Haven satisfied the statutory requirements to be an ICF. It met all of the standards established by the Secretary. Far from there being any question about that, Middletown Haven was applauded by the responsible professional federal reviewer as an "ideal ICF" and an "excellent facility." J.A. 11c, 19c. The only basis for seeking recovery of the federal support that had been given for Middletown Haven was that it specialized in the care of people with mental conditions, including those discharged from state mental hospitals, thereby allegedly making it an IMD and ineligible for

federal financial support."[38]

B. The IMD Provisions of the Statute Do Not on Their Face Preclude Coverage For ICFs Specializing in Care of Residents With Mental Conditions.

"[T]he starting point for interpreting a statute is the language of the statute itself." Consumer Product Safety Commission v. GTE Sylvania, Inc., 447 U.S. 102, 108 (1980). In this case there is no express statutory definition of the term "institution for mental diseases." But there is an express statement of what

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[38] While Middletown Haven was a model ICF, it is important to stress that it did not attempt to meet the more exacting standards established by DHHS regulations for institutions furnishing the higher level of care expected of mental hospitals participating in the Medicaid program. See 42 C.F.R. §§442.303, 442.333, 442.346 (1983) and compare the stricter requirements for staff ratios and qualifications and service programs in 42 C.F.R. §§405.1036 and 405.1038 (referred to by 42 C.F.R. §440.140(a) (1983)). For example, Middletown Haven did not admit "acute mental disorder" cases (J.A. 43a) and its physician-psychiatrists worked only part-time at the facility. J.A. 2c-3c.

that term does not include. It is contained in section 1902(a)(21) (42 U.S.C. §1396a(a)(21)), which defines "nursing facilities" (as well as "community mental health centers") as alternatives to "public institutions for mental diseases."

Nothwithstanding this specific statutory statement, the Department relies on two other provisions of the statute that use the term "institution for mental diseases" to support its view that the term embraces nursing facilities. One is contained in the description of ICF services that was added in 1971 to the list of services covered by Medicaid. That description is:

> "intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined ... to be in need of such care." 42 U.S.C. §1396d(a)(15) (emphasis added).

Looking just at the statute alone, the parenthetical phrase in sub-paragraph (15) states that ICF-level services are not covered if provided in a tuberculosis or mental disease institution. That ICF services might be provided other than in an ICF is expressly contemplated by the statute.[39]

Thus, the parenthetical phrase in sub-paragraph (15) does not mean that ICFs

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[39] See section 1905(c) (42 U.S.C. §1396d(c)), providing that ICF-level services may be furnished in a skilled nursing facility or a hospital. DHHS regulations also recognize that ICF services may be furnished in various settings, including a mental hospital. See, e.g., 42 C.F.R. §440.150(d) (1983) (providing that the term "intermediate care facility services" may include services furnished in a distinct part of a facility other than an ICF if the distinct part meets certain standards); 42 C.F.R. §442.254 (1983) (setting standards for hospitals and skilled nursing home facilities offering ICF services). Congress has also recognized the need to use hospitals to provide long-term ICF services, especially where there are insufficient ICFs in the community to meet the demand. See Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, 94 Stat. 2599, 2609.

can themselves be IMDs, but only that federal support is not available for ICF-level services furnished in an IMD.[40] As has already been demonstrated, this provision carries out the powerful Congressional preference for deemphasizing reliance, for the care of the mentally ill, on the large, remote and forbidding institution that was the Congressional conception of a mental hospital.[41] That

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[40] While Petitioner asserts that the Department's position is not supported by the statute on its face, it recognizes, as has this Court (see Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981)), that the Medicaid statute is far from a model of clarity. Petitioner's argument as to the meaning of the statute on its face involves a literal reading of the statutory terms, although no more literal than is called for by the immensely complex statutory draftsmanship involved. That the literal reading accords with Congressional intent is amply demonstrated by the full history of the statutory provisions and concepts involved, which is detailed in section III infra.

[41] Private psychiatric hospitals might not have exhibited these characteristics; however, Congress did not differentiate between public and private
(footnote cont'd)

preference answers the assertion of the court below that it could "perceive no reason whatsoever to conclude that Congress intended to deter the development of ICF's within the traditional hospital." Pet. App. 9a.[42]

The second provision on which the Department relies is the general exception that follows the entire list of Medicaid-covered services for "care and services for any individual who has not attained 65 years of age and who is a

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(footnote cont'd)
institutions in the IMD provision, although the predominant if not exclusive focus was on the very singular characteristics of public mental hospitals, which housed over 95 percent of the residential mental patients.

[42] The court's statement that no congressional purpose calling for "... an artificial distinction [between an ICF operating within an IMD and an independent ICF] has been offered, and we have found none in our independent research," (Pet. App. 9a) betrays a lack of understanding of how mental hospitals had evolved and the strong adverse reactions to them of government officials and professional experts.

patient in an institution for tuberculosis or mental diseases." 42 U.S.C. §1396d(a)(18)(B). This is the successor to the original IMD provision first adopted in 1950 in connection with the adult assistance titles of the Act.

Even aside from the showing below that Congress meant the term IMD to describe only mental hospitals, this provision cannot be read to preclude Medicaid coverage for ICFs specializing in the care of people with mental conditions. For when this provision was adopted, ICFs were not yet a part of the Medicaid program. When they were subsequently brought under the program, they were defined as facilities caring for people with mental (as well as physical) conditions without age limitation. This was a much more particularized statement by Congress of its intention than is

contained in the general IMD exception. This later, more specific expression of intent controls over the earlier, more generalized provision. See Morton v. Mancari, 417 U.S. 535, 550-51 (1974); Bulova Watch Co. v. United States, 365 U.S. 753, 758 (1961). To hold otherwise and apply the IMD exception to ICFs would require the conclusion that Congress, without any reference to the IMD provision, meant to undo the very act that it had taken in adding to the statute ICF coverage for eligible people of all ages with mental conditions.

The court below sought to avoid that contradictory conclusion by suggesting that the reference to "mental condition" in the definition of an ICF "may" mean something less than all mental patients. It speculated that it could mean only mental patients over 65, or perhaps only

mentally retarded people, or perhaps mental cases in ICFs that did not specialize in their care. Pet. App. 8a. Yet the terms of the statute do not embrace any of these limitations, and the court cited no evidence to suggest that Congress meant any such limitations to be engrafted on to its use of an unconditional term.

The court below also relied on the final sentence in the statutory definition of an ICF. That sentence states:

> "With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d) ... any public institution or distinct part thereof for mental diseases or mental defects." 42 U.S.C. §1396d(c).

Subsection (d) brings within the ambit of Medicaid coverage services in public institutions for the mentally retarded, provided that a number of very specific

conditions, not pertinent to general ICF care, are met. To the extent it applies to this case the last sentence supports the State, for it is confined to "public" institutions, and under normal rules of English this would convey the meaning that private ICFs for mental diseases or defects, like Middletown Haven, are to be covered by Medicaid.[43]

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[43] The last sentence of the ICF definition, which was not included in the definition when ICF coverage was under Title XI, had its origin in H.R. 17550, Social Security Act Amendments introduced by Ways and Means Committee Chairman Mills and adopted by that Committee and the House. The stated purpose of the provision (H.R. Rep. No. 1096, 91st Cong., 2d Sess. 124 (1970)) was to eliminate federal support for care in public institutions, particularly those for the mentally retarded, which a few states were seeking to bring within the ambit of Title XI. See Hearings on Social Security Amendments of 1970 Before the Senate Committee on Finance, 91st Cong., 2d Sess. 505-15, 1185 (1970) (hereafter cited as "1970 Senate Hgs."). That effort had been fostered by a Departmental interpretation that federal support for care in institutions for the mentally retarded was available without regard to age and without the kind of commitment to better treatment that

(footnote cont'd)

In short, taking the statute on its face, the ordinary meaning of the definition of ICF would clearly encompass such facilities that specialize in the care of patients with mental conditions, and the references to IMDs do not warrant the contrary conclusion.

C. Legislative and Administrative History Confirms That the IMD Exclusion Applies Only To Mental Hospitals.

1. Evolution of the IMD Exception

State assumption of responsibility for the care of the mentally afflicted in

(footnote cont'd)
the Long Amendment required for coverage of the aged mentally ill in IMDs, as long as the facility otherwise met the definition of a hospital or a nursing home. See Handbook, §D-4620.

The House provision was incorporated into the ICF definition by the Senate Finance Committee in connection with its first proposal to bring ICFs under the Medicaid program. S. Rep. No. 1431, 91st Cong., 2d Sess. 147 (1970). The Senate adopted the proposal as part of a package of Social Security Act amendments. 116 Cong. Rec. 43868 (1970).

public mental hospitals has been a prominent fact of life for over a century, and Congress deferred to that assumption of responsibility when it developed the public assistance programs under the Social Security Act. But the deference was no broader than the extent of the assumption of responsibility. There was no comparable record of state support for the mentally ill in other settings, such as nursing facilities. In fact, as the Joint Commission later found, the nation's care of its mentally ill was deficient because of the unavailability of such resources. Because there was no predicate for federal abstention beyond mental hospitals, the intent and purpose of the IMD exception was confined to that setting, as is shown in the report of the Advisory Council on Social Security that initiated the IMD exception

in 1947, the Congressional report embracing the recommendation, and the 1960 debates over whether the exception should be removed. See pages 33-38, supra.[44]

The reports and debates that produced the 1965 Medicaid legislation abound with evidence of intent to keep the IMD clause confined to mental hospitals. The Long Amendment, which narrowed the IMD exclusion for Medicaid (for persons over 65) in return for state commitment to development of comprehensive programs for

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[44] The 1960 amendments adopted the program of medical assistance for the aged, the precursor to Medicaid. Pub. L. No. 86-778, §601, 74 Stat. 924, 991. An IMD exception was included in that program in terms identical to those used in the 1950 law and in the subsequent Medicaid law (but for the over-65 exception). During the consideration of the Medicare-Medicaid legislation, the House Ways and Means Committee issued a document describing the 1960 exception as applying to services furnished to patients in "mental hospitals." House Committee on Ways and Means, 89th Cong., 1st Sess., Summary of Major Provisions of Medical Assistance for the Aged Program 1 (Comm. Print 1965).

the care of the mentally ill, including alternatives to care in IMDs, was first adopted as a Senate floor amendment to a 1964 bill, and grew out of discussions between Senator Long, Senator Carlson of Kansas and DHEW. 110 Cong. Rec. 21348-49 (1964).[45] Both Senators Long and Carlson emphasized the importance of developing alternatives to the "traditional large State mental hospitals" (id. at 21349) and identified nursing homes as among the alternatives to IMDs that were to be encouraged. Id. at 21348, 21349.

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[45] The Senate Finance Committee had adopted a provision simply eliminating the IMD exclusion from the adult assistance titles of the Social Security Act, as the Senate had unsuccessfully sought to do in 1960. See pages 37-38, supra. 110 Cong. Rec. 21085 (1964); S. Rep. No. 1513, 88th Cong., 2nd Sess. 7, 17 (1964). The subsequent discussions led to inclusion of the provisions intended to encourage state comprehensive mental health planning, including development of alternative settings.

This theme permeated the extensive discussion of this subject in the Committee reports on the 1965 legislation, 1965 H. Rep. 126-29 and 1965 S. Rep. 144-47.[46] The entire tenor of the reports is to distinguish between the traditional large state mental hospital and more modern settings and approaches, including nursing homes, for treating the range of conditions that are grouped under the general heading of mental illness.[47]

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[46] Because of the significance of these reports (which are similar in content) there is attached hereto as Appendix B the relevant excerpt from the Senate Finance Committee Report.

[47] The Long Amendment, in addition to limiting the IMD exception as incorporated into the new Medicaid program, applied also to the titles of the Act under which income assistance was provided to the aged, blind and disabled. In the latter two categories, an exclusion for care in IMDs was retained, but limitations on the care of mental illness in general hospitals were eliminated. See 1965 H. Rep. 193-94; 1965 S. Rep. 216-17.

Given this explicit and extensive statement of Congressional intent, and the resultant statutory provisions that describe nursing facilities and community mental health centers as among the alternatives to IMDs (42 U.S.C. §1396a(a)(21)), it is not possible to credit the Department's position that when Congress used the term "institution for mental diseases" in defining medical assistance in the new Title XIX, it meant that term to extend broadly beyond the traditional mental hospital to include nursing homes.[48]

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[48] There is another indication to support petitioner's interpretation of IMD. The 1965 law extended Medicaid coverage, for people of all ages, to treatment of psychosis or tuberculosis cases in public general hospitals. In this respect, the law finally interred an exception that had been adopted in 1950 (see note 21, page 35, supra) and partially repealed in 1960 (see note 26, page 38, supra). Under the Department's interpretation, these psychosis or tuberculosis

(footnote cont'd)

The reference on which the Department has principally relied is the parenthetical clause "other than such services in an institution for tuberculosis or mental diseases" that appears in the listings of inpatient hospital services, skilled nursing facility services and intermediate care facility services in the section defining covered Medicaid services. 42 U.S.C. §1396d(a)(1), (4) and (15). These parenthetical clauses were not included when the list of covered services first appeared in the 1960 legislation adopting the program of medical care for the elderly poor. Pub. L. No. 86-778, §601, 74 Stat. 924, 991.

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cases, if under age 65, would lose Medicaid eligibility upon discharge from a public general hospital into an ICF that specialized in the care of such cases. This result, which discourages the use of the less intensive and less costly care setting, is directly in conflict with well-expressed Congressional objectives.

Their inclusion was unnecessary because of the general IMD exclusion that appeared at the end of the list of covered services (as does the modified IMD provision in the Medicaid law). The question then is why these parenthetical clauses were added when the listing of services was incorporated into Title XIX in 1965.[49]

The Senate Report supplies the answer. As in the 1960 law, certain of the listed services were mandatory -- they had to be provided in order for the state to qualify its program. Inpatient hospital services and skilled nursing facility services for people over 21 were among the mandatory services. See 42 U.S.C.

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[49] This discussion relates to the provisions for inpatient hospital and skilled nursing facility services, since the ICF provision was not part of the 1960 law and was not added to Title XIX until 1971.

§1396a(a)(10). The purpose of the parenthetical clause was to "help make it clear that it is optional rather than mandatory for a State to include services for the aged in tuberculosis or mental institutions." 1965 S. Rep. 81. It is a fair conclusion, since there is no legislative evidence to the contrary, that no broader purpose was intended when the identical parenthetical clause was included in the definition of ICF services when it was added to the law in 1971.

2. Congressional Acknowledgment of the Limited Scope of the IMD Exception

Congressional references to the IMD exception since enactment of the Medicaid Act in 1965 confirm that it was meant to embrace only mental hospitals and not other categories of facilities that care for the mentally ill.

When it was proposed in 1971 to bring ICFs under Medicaid, Senator Long on behalf of the Senate Finance Committee explained:

> "The committee amendment is designed to make it clear that intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital." 117 Cong. Rec. 44721 (1971) (emphasis added).

The Department's current notion, that ICFs specializing in the care of mental patients are barred from Medicaid participation by the IMD clause, cannot be squared with this statement of intent to cover under Medicaid, without age limitation, facilities that care for patients who, absent the availability of ICFs, would be placed in mental hospitals.

In 1972, when the Act was amended to provide federal support for "inpatient

psychiatric hospital services" for children, the Senate Finance Committee again equated institutions for mental diseases with mental hospitals.[50]

Finally, the version of the 1972 Amendments adopted by the Senate contained a provision authorizing demonstration projects to evaluate the extension of "medicaid inpatient mental hospital coverage" to the mentally ill between the ages of 21 and 65. H. R. 1, §299B (as passed by the Senate on October 5, 1972); S. Rep. No. 1230, supra, at 281. The proposal was dropped in conference. H.R. Rep. No. 1605, supra, at 65. It is hard

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[50] S. Rep. No. 1230, 92d Cong., 2d Sess. 281 (1972). See also H.R. Rep. No. 1605, 92d Cong., 2d Sess. 65 (1972). If the Department's view is correct, it means that in 1972 Congress deliberately amended the law to permit Medicaid coverage for children in the most expensive type of facility (psychiatric hospitals) but declined to cover them when cared for in less expensive and more accessible facilities like ICFs.

to believe, in light of all that had gone before, that the Senate would take a step toward eliminating the IMD exception for all mental hospital cases, but leave it in place for those under 65 in alternative, smaller, and less remote facilities like nursing homes. This Senate action adds still further confirmation to the conclusion that the IMD exception was never intended to apply to such facilities in the first place.[51]

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[51] Also in 1972 there was a "technical" amendment to the listing of covered Medicaid services to add "intermediate care facility services" to 42 U.S.C. §1396d(a)(14), which previously had listed inpatient hospital services and skilled nursing facility services for individuals 65 years of age or older in an institution for tuberculosis or mental diseases as eligible for Medicaid. As stated by the Senate Finance Committee, where the provision originated, the purpose of the amendment was to make clear that Medicaid coverage was available for ICF services to the elderly even when provided in mental institutions. S. Rep. No. 1230, supra, at 321. Contrary to arguments of the Department, this change did not "prove" that ICFs could themselves be IMDs. Rather, it

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3. Administrative Recognition of the Limited Scope of the IMD Exception

The responsible administrative officials prior to and at the time the Medicaid law was developed were fully aware that the IMD exception extended only to mental hospitals. This was the explanation given by DHEW Secretary Celebrezze to the Senate Finance Committee in 1964. He reported "[t]he main reason for this exclusion is that most of these hospitals are public institutions and are supported by public funds." Hearings on H.R. 11865 Before the Senate Committee on Finance, 88th Cong., 2d Sess. 108 (1964) (emphasis added).[52]

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confirms the Congressional awareness that ICF services might be made available in mental hospitals. See page 69, supra.

[52] Senator Ribicoff, who preceded Mr. Celebrezze as HEW Secretary, likewise referred to the IMD
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The Department acted on this understanding after Medicaid was enacted. In June 1966, it issued Supplement D to the Handbook of Public Assistance Administration, setting forth the initial regulations to implement Medicaid.[53] The Handbook equated an IMD with a mental hospital; it required, in order for an IMD to qualify for coverage of its over-65 patients, that the institution meet the requirements for a psychiatric hospital under the Medicare law (although for three years an IMD could qualify if it was licensed as a mental hospital under state law and met other standards).

(footnote cont'd)
exclusion as a "restriction on Federal participation in assistance programs where the recipients are in mental or tuberculosis hospitals" and the state had assumed responsibility for their care. 111 Cong. Rec. 15805 (1965) (emphasis added).

[53] The Handbook was then the source of regulations to carry out the Social Security Act. See King v. Smith, 392 U.S. at 319 n.16 (1968).

Handbook, §D-5141.14(d).[54] Essentially the same provisions were incorporated into the formal regulations first published in 1969. 45 C.F.R. §249.10(b)(14)(iv) (1970).

If the Department's current position that the term IMD embraces nursing facilities is correct, it means that immediately after Medicaid was passed, and notwithstanding the emphasis in the Long Amendment on the importance of moving people out of mental hospitals and into alternative facilities, DHEW defined an IMD eligible for federal support for patients over 65 solely in terms of a

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[54] The Handbook also contained a statement of the exclusion of any individual under age 65 who is a "patient in an institution for ... mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with ... mental diseases (whether or not it is licensed)." Handbook, §D-4620.2 (Pet. App. 16d).

mental hospital, and thereby precluded financial support for residents over 65 in skilled nursing facilities specializing in care of mental conditions. There is no evidence that the Department meant such an emasculation of the well-elaborated Congressional purpose. Rather, the limitation of the IMD definition to hospitals is a powerful indicator of the limited scope then ascribed to the statutory exclusion.

The Department's understanding of the limited scope of the IMD exception was also manifest in a Report supplied at the request of the Senate Finance Committee.[55] After identifying the "specific statutory exclusion of payment for care

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[55] DHEW, Social Security Administration, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971) (hereafter cited as "Report").

of patients under the age of 65 in mental institutions" (emphasis in the original) the Report listed "[s]ervices important in the treatment of the mentally ill covered under Medicaid" (emphasis added) and included skilled nursing home services and services in psychiatric wards of general hospitals, among others. Report, supra, at 36.[16] (ICF services were not listed because, at the time of the Report, Medicaid had not been amended to incorporate ICFs.) An appendix summarizing the legislative history of federal financing of psychiatric services describes the IMD exclusion as a limitation on mental hospital coverage. Report,

[16] The Report later pointed out that the IMD exclusion for persons under age 65 precluded Medicaid payment for inpatient hospital services or skilled nursing home services in a "psychiatric institution." Report, supra, at 39-40.

supra, at 47-49.[17]

That the Department did not view the IMD exclusion as going beyond mental hospitals to embrace nursing homes that specialized in the care of the mentally ill is evident from the regulations adopted to implement Title XI when it was added to the law in 1967 to permit payment for services to the aged, blind and disabled in ICFs. Interim Policy Statement No. 23, 33 Fed. Reg. 12925 (1968), modified 34 Fed. Reg. 9782 (1969), 42 C.F.R. §234.130 (1970). The regulations define an ICF in terms of caring for people with physical or mental conditions, without any intimation that an ICF specializing in the care of mental conditions would be deemed an IMD and

[17] The cited portions of the Report are attached hereto in Appendix C.

disqualified.[88] The omission was not inadvertent. The regulations do make reference to the other major exclusion from coverage in the public assistance titles -- that for public institutions (other than medical institutions). See pages 33-34, supra.[89] The failure in this context to mention the IMD exclusion is yet another sign that responsible officials did not underrtand it to apply beyond the narrow confines of mental hospitals.[90]

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[88] There was an IMD provision in each of the adult assistance titles. See page 34, supra.

[89] The "public institution" exception was included in the Medicaid program. 42 U.S.C. §1396d(a)(18)(A).

[90] In 1970, then-DHEW Secretary Richardson proposed a differentiated matching rate schedule to encourage greater use of ICFs, which offered a "more appropriate level" of care for many residents of skilled nursing facilities and "mental institutions." 1970 Senate Hgs. 68-69. The Secretary's rationale extended to all mental

(footnote cont'd)

The opposite view adopted later by the Department, which is so out of keeping with the purposes of the Medicaid statute as expressed in the Long Amendment, did not prevail during the critical years after Medicaid was enacted and up through the time that intermediate care facilities were brought under the program. Thus, the relevant contemporaneous administrative history is consistent with the legislative history -- the IMD exclusion was meant to apply to mental hospitals, and not to nursing homes and the other alternative settings for the care of the mentally ill.

4. The Courts' Understanding of the IMD Exclusion

While the precise scope of the IMD

(footnote cont'd)
hospital patients, not just those 65 and over (id. at 78-80), showing that the Department still did not view the IMD exception as applying to ICFs.

clause has never been before this Court for decision, the Court has considered it and has characterized it as referring to mental hospitals. In Schweiker v. Wilson, 450 U.S. 221 (1981), the issue was the constitutionality of a provision of the Supplemental Security Income program that was affected by the IMD exclusion.[61] The Court quoted the legislative history to the effect that the reason for the exclusion was that "long-term care in such hospitals had traditionally been accepted as a responsibility of the States." Id. at 237 n.19 (emphasis added).

The dissenting opinion in Schweiker v. Wilson was even more explicit in re-

[61] The question in that case was whether the payment of subsistence allowances to certain SSI recipients residing in institutions, but not to those aged 21 through 64 in IMDs, created a constitutionally impermissible classification.

ferring to the IMD exclusion in terms of mental hospitals. It stated:

> "The residual exclusion of large state institutions for the mentally ill from federal financial assistance rests on two related principles: States traditionally have assumed the burdens of administering this form of care, and the Federal Government has long distrusted the economic and therapeutic efficiency of large mental institutions." Id. at 242 (citing the 1965 legislative history).

The dissent added, "Residence in a public mental hospital is rationally related to whether the Congress should pay for the patient's treatment." Id. at 246 (emphasis added).

Neither the majority nor dissenting opinions gave any indication that the term "institution for mental diseases" might apply to alternative care settings such as intermediate care facilities. On the matter of relevance to this case, the Court in Schweiker was unanimous in confining the IMD exclusion to mental

hospitals.[62]

5. The Faulty Analysis of the Court of Appeals

Against all of this evidence, the court below concluded that the IMD exclusion was meant to encompass not just mental hospitals but any kind of residential care facility for the mentally

[62] The Court of Appeals for the Eighth Circuit in Minnesota v. Heckler (Pet., App. E) followed this Court's decision in Schweiker v. Wilson in rejecting the Department's application of the IMD exception to ICFs. Pet App. 18e. Other courts that have considered the IMD exclusion also have characterized it only in terms of mental hospitals, based on a reading of the legislative history. See, e.g., Doe v. Colautti, 592 F.2d 704, 709 (3d Cir. 1979) (referring to exclusion as relating to "inpatient care at a psychiatric hospital"); Kantrowitz v. Weinberger, 388 F. Supp. 1127, 1130 (D.D.C. 1974), aff'd, 530 F.2d 1034 (D.C. Cir.), cert. denied, 429 U.S. 819 (1976) (describing exclusion as relating to payments for inpatient care in mental hospitals); Legion v. Richardson, 354 F. Supp. 456, 459 (S.D.N.Y.), aff'd sub nom. Legion v. Weinberger, 414 U.S. 1058 (1973) (noting Congress' belief that care of the mentally ill "in state hospitals" was the responsibility of the states). The latter two decisions were cited by the court with approval in Schweiker v. Wilson, 450 U.S. at 237 n.19.

ill. The court's conclusion was heavily influenced by its failure to grasp the significant difference in Congressional attitude toward mental hospital care compared to care in other settings. See pages 54-55, supra, and Pet. App. 9a, 10a. From this starting point, the court dismissed the legislative evidence because of "the undeniable fact that Congress has never lifted the longstanding IMD exclusion for persons under age 65 or even indirectly implied such a purpose in the legislative history." Pet. App. 12a. Since Petitioner has never contended that Congress meant to lift the IMD exclusion for persons under 65, this "undeniable fact" does not advance the inquiry. Rather, it obscures the real question, which is what scope was intended initially for the IMD exception.

On this score, the court's opinion gave no weight to any of the expressions of intent or purpose by members of Congress or the responsible administering officials.[63] Neither did it advert to the court decisions pertaining to the IMD clause. Instead, it undertook its own review of Congressional hearings held after Medicaid was adopted, and based on certain statements of witnesses (other than members of Congress or administration spokesmen), concluded that the IMD provision was understood to cover all kinds of residential facilities, not just

[63] The court dismissed the significance of the Long Amendment, contending that the requirements for developing comprehensive mental health plans and alternatives to mental hospital care applied only with respect to the elderly. Pet. App. 11a-12a. This argument completely misses the point. The significance of the Long Amendment is that it expressly distinguished between IMDs on the one hand and nursing facilities on the other. (See pages 44-45, supra). This significance is unaffected by the court's argument.

hospitals.[64]

This reliance on the least authoritative and most ambiguous kind of evidence of prior legislative intent to override the tide of contrary evidence described above yields the least dependable basis on which to predicate judgment. But beyond this, the court's analysis was misguided; the passages cited and other similar excerpts from the several-year hearing record confirm the well-expressed legislative intent to confine the IMD exception to mental hospitals.

In each of the three passages cited by the court below, the witness was seeking elimination of the IMD exclusion for persons under age 65, and in each case the witness stressed the desirability of

[64] The Department has never previously relied upon the excerpts on which the court pinned its decision.

obtaining Medicaid coverage for care of all persons in mental hospitals. The court cites the 1967 testimony of Dr. Robert W. Gibson on behalf of the American Psychiatric Association because he suggested that the IMD exclusion precluded Medicaid coverage not only in hospitals but also in a community mental health center. Pet. App. 12a.[66] The court omitted reference to two other witnesses in the same year who described the IMD exclusion (repeal of which they were seeking) as applying solely to mental

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[66] Dr. Gibson's reference to community mental health centers was incorrect; the HEW report submitted a few years later showed the extent to which states did cover community mental health center services under Medicaid. Report, supra, at 37-38 (App. C). Medicaid coverage of these centers was not mandatory and, in 1967, when Medicaid was still in its infancy, there was little coverage of community mental health centers. Id.

hospitals.[66]

The court below says that Congress never responded to the pleas of Dr. Gibson and others. But that conclusion is unwarranted. The outcome of the 1967 hearings was the law authorizing federal support for ICF care, which was defined to include care of people with mental conditions. So to the extent Dr. Gibson can be read as posing a problem for the care of the mentally ill in residential facilities other than mental hospitals,

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[66] Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance, 90th Cong., 1st Sess. 1748 (1967) (testimony of Dr. Leonard Ganser, National Association of State Mental Health Program Directors, who sought removal of "the exclusion against hospitals that specialize in treatment of mental illness"); Social Security Amendments of 1967: Hearings on H.R. 5710 Before the House Comm. on Ways and Means, 90th Cong., 1st Sess. 1665, 1675 (1967) (testimony of Dr. Charles L. Hudson, President of the American Medical Association, that the IMD exception excluded the "medically indigent patient ... under 65 ... [from] psychiatric treatment ... in a private or public mental hospital.").

there was an immediate, direct and affirmative response.

The court below was quite confused about the significance of comments in the 1970 hearings, particularly those addressed to a provision that eventually was added as the last sentence of the definition of "intermediate care facility" when that category was added to Medicaid in 1971. As shown above (p. 33), that provision was confined to public institutions.[67] The question

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[67] The submission of the Illinois Department of Public Aid crystallized the conceptual question that was raised by the provision as contained in the House bill:

> "Where 'intermediate care' is all that is required but placement cannot be found in outside facilities, any public hospital for mental diseases is discouraged by the concluding paragraph of section 225 of the Bill ... from establishing a section in the institution to provide intermediate care. Federal aid is prohibited to patients in such a section of a public hospital." 1970 Senate Hgs. 1185 (emphasis added).

discussed in the 1970 hearing excerpts was whether public institutions for the mentally retarded should be brought under Medicaid (or whether it was already possible to do so). This debate had nothing to do with whether the IMD exclusion covers nursing homes. The real significance of the 1970 hearings is in the repeated references by Senator Long to IMDs as synonymous with mental hospitals. See 1970 Senate Hgs. 537, 539, 548, 939.

The court below deemed "most important" the testimony of state mental health directors Leopold and Gaver before the Senate Finance Committee in January 1972; yet the court misunderstood entirely the import of that testimony. The witnesses were pushing for elimination of the IMD exception for persons under age

65.[68] They urged "the principle of equity," not, as the court below thought' (Pet. App. 14a), to obtain coverage for the under-65 group in all settings, but rather so that "publicly administered facilities as well as private mental hospitals can receive payment ... on the same basis that general hospitals receive such benefits." 1971-72 Senate Hgs. 929.[69]

Senator Long expressed sympathy for

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[68] To support their position, the witnesses argued that the Long Amendment had been very successful for those 65 and over in mental hospitals, pointing to the substantial transfer of elderly patients from hospitals to other facilities, including SNFs and ICFs, even though federal funding had been made available for their hospital care. The court below erroneously construed this report of transfers to ICFs and SNFs as evidence that payment for care in those facilities was made possible only because of the IMD exception for the elderly. Pet. App. 14a.

[69] General hospital care for mental illness is covered under Medicaid. See note 29, page 42, supra.

the proposal, but suggested that it might not be acceptable unless there were strict standards imposed on the nature of the care to be provided in the mental hospitals. Id. at 929. Contrary to the discussion of this point by the court below, the failure to include nursing facilities in this suggestion merely confirms that Senator Long well understood the availability under existing law of Medicaid payments for under-65 mental cases in these kinds of facilities.[70]

The record of hearings throughout the

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[70] This understanding was expressed by Senator Long when he explained the legislation transferring the ICF provisions to Medicaid in 1971. See page 69, supra. The court below sought to avoid the impact of this explanation, saying that "it is wholly plausible to conclude" that the explanation referred only to care for the elderly. Pet. App. 15a. But Senator Long's statement was not so limited, and the court's only basis for engrafting such a limit on his comments was its erroneous understanding of the import of the hearings some weeks later that are discussed above.

period following enactment of Medicaid confirms the limited office of the IMD exclusion. The court below went awry because it built on implications, speculation and "plausible" inferences, none of which was found in the words it was analyzing, and on an erroneous initial premise that the IMD exception covered all types of residential facilities absent an explicit statutory limit on its scope. That premise assumed the very question to be answered. An objective view of the legislative evidence, approached without a predisposition either way, clearly reveals that the IMD exception was never meant tc extend beyond mental hospitals to embrace alternative residential settings like intermediate care facilities.

III. THE CHALLENGED DISALLOWANCE ACTION UNDERMINES THE FEDERALISM CONCEPT ON WHICH THE PUBLIC ASSISTANCE PROGRAMS ARE BASED.

Even if it were less clear that the term "institution for mental diseases" does not embrace intermediate care facilities like Middletown Haven, the disallowance action would still be unwarranted. In this case, the disallowance is an after-the-fact withdrawal of federal financial support that was inconsistent with the premises on which Connecticut received the federal funds and paid for the needed services. As such, it conflicts with the constitutional predicate on which the Medicaid program rests.

A. The Disallowance Was Based on New and Uncertain Policies Not Implemented Until After the Federal Funds Were Received and Spent.

This is not a case where the Depart-

ment seeks return of federal matching funds upon discovery on audit that incorrect amounts were paid to the state, or that clearly established and specific conditions to payment were not satisfied.[71] Rather, the disallowance is predicated on a legal interpretation never clearly enunciated to the states, and was dependent upon a subjective after-the-fact audit review that applied nonspecific criteria of doubtful validity.[72]

The issue of applying the IMD exclusion to ICFs and SNFs surfaced in three

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[71] Cf. Bell v. New Jersey, 461 U.S. 773 (1983), where the only issued decided was the authority to recover incorrect payments.

[72] The issue is thus "whether a State can be required to repay if ... the claim of violation rests on a new regulation or construction of the statute issued after the state entered the program and had its plan approved." Bell v. New Jersey, 461 U.S. at 793 (White, J. concurring).

internal memoranda to regional officials in 1975 and 1976, the last two of which reflect confusion and disagreement as to the new policy.[73] J.A. 5d-11d.[74] Little if anything was done by the Department to follow up on its new approach until late 1977, when it sought to clarify the "criteria" to be used in determining when SNFs and ICFs would be classified as IMDs. An October 1977 internal opinion by an Assistant Regional Attorney, apparently widely distributed among the regions and supplying the basis on which the subsequent audits were

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[73] The internal memoranda apparently were issued after a General Accounting Office reviewer raised the question of applying the IMD exception to nursing homes. Comptroller General Report to the Congress: "Returning the Mentally Disabled to the Community: Government Needs to Do More" 90-91 (January 7, 1977).

[74] Connecticut became aware of the issue of the extension of the IMD exception to SNFs and ICFs in 1976. J.A. 3b.

conducted, identified eight relevant criteria. Pet. App. 27d-28d.

The opinion warned that some of the criteria "are more probative" than others, and admonished that "every indication of any significance that a given facility is primarily engaged in IMD activity should be marshalled to fulfill the regulatory mandate that the determination be on the basis of the facility's 'overall character' ...." Id. at 28d-29d (emphasis added).[75]

The audit of Middletown Haven in December 1979 sought to apply these criteria. J.A. 2a-13a.[76] The audit team

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[75] The references to "overall character" and "primarily engaged in IMD activity" are to the published regulations defining institutions for mental diseases. See page 8, supra.

[76] The audit team added two more criteria of its own: (1) the presence of staff specialized in the care of the mentally ill, and (2) results of
(footnote cont'd)

reviewed the records of every resident of Middletown Haven between January 1977 and September 1979, and concluded that well over half had mental disabilities. Based on this and the other criteria, it concluded that the overall character of Middletown Haven was that of an IMD. J.A. 24a.

The Department acknowledges that the states may not have had notice of all the criteria on which the various audits were based. Pet. App. 30d. But it says the criteria were never intended to be "criteria as such." Rather, they were "merely guidelines" in identifying possible IMDs, and no one of the criteria "was ever considered determinative with respect to the nature of the facility."

(footnote cont'd)
independent professional review by state review teams. J.A. 13a.

The criteria represented internal "clarification" of published regulations not intended "for the guidance of the public;" it was the regulations alone, according to the Department, that clearly placed states on notice of how the IMD exception would be applied. Pet. App. 30d-31d.[76]

But the published regulations are manifestly inadequate to inform states of the Department's conception of the IMD exclusion. The content of the regulations relied upon by the Department has not changed significantly since it was first incorporated into the Handbook of Public Assistance Administration shortly after Medicaid was enacted. Yet when these provisions were adopted they could

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[76] The regulation on which the Department relies, as it read at the time of the audit, is set forth in the Joint Appendix (J.A. 2e).

not have informed states about the Department's current interpretation. As shown, the Department then did not hold to that interpretation, and the Handbook expressly confined IMDs to mental hospitals. See pages 72-78, supra. Moreover, the regulation is far too vague to permit reasonable judgments as to its meaning, even if states had reason to believe that it could be applied to nursing facilities, as is evidenced by the Department's perceived need to develop implementing criteria.[78]

The criteria would not have supplied the missing notice even if Connecticut had been apprised of them before certify-

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[78] The circular statement of the Assistant Regional Attorney's memorandum of late 1977 that the ultimate aim of the regulation is to identify those facilities "primarily engaged in IMD activity" (Pet. App. 28d) highlights the absence of meaningful notice in the regulation.

ing Middletown Haven as a Medicaid provider, for they shed no light on the difficult issues inherent in identifying "mental disabilities," differentiating them from physical ailments, and determining when such a disability is the primary reason for the placement of the resident. See Pet. App. 34d, 36d-37d.[79]

Contributing to the insufficiency of the criteria is the fact that they are inconsistent with the statutory purpose. In large part they rely, to justify classification as an IMD, on factors demonstrating the use of the facility as an alternative to mental hospital confinement. Yet, the statute expressly

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[79] The fact that a reviewing agency determines later that the auditors' resolution of these difficult issues was reasonable (id.) does not make up for the absence of any basis for a state in advance to know with reasonable certainty what the governing standards for coverage are going to be.

describes and encourages the development of these "alternatives" for use <u>in lieu of</u> IMDs. 42 U.S.C. §1396a(a)(20) and (21).[80] The Eighth Circuit Court of Appeals concluded that the criteria were inconsistent with the statute, because they turn principally on the diagnosis of the residents of the facilities and thereby encroach on the evident statutory purpose of bringing Medicaid coverage to ICFs that care for people with mental diagnoses. Pet. App. 21e-22e.

The foregoing demonstrates that the

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[80] The validity and effectiveness of the criteria have been questioned even by responsible officials within the Department. See Pet. App. 22e, n.25. And while the Department never sought public input before utilizing the criteria, in 1980 it requested public comment on what criteria should be used in classifying facilities as IMDs, including the possibility of a significant change in the percentage of residents with "mental disabilities" that would justify categorization as an IMD. 45 Fed. Reg. 47368, 47372 (1980). No further action has been taken.

approach utilized by the Department to implement its new interpretation of the IMD provision as applicable to SNFs and ICFs was flawed, and that Connecticut could not have known until the results of the December 1979 audit were obtained that expenditures made between January 1977 and September 1979 would be found ineligible for federal support by the Department. In every practical sense this was after-the-fact action -- an imposition of limitations that were not applicable or discernible during the period that Connecticut received and expended the federal funds in issue.

B. After-The-Fact Disallowances Are Impermissible Under the Public Assistance Titles of the Social Security Act.

The relationship of the states to the federal government under the public assistance provisions of the Social

Security Act is not that of regulated enterprise and regulator. Rather, the statute contemplates a joint endeavor between two sovereigns, with the states having the principal responsibility for carrying out the programs and for defining their scope within the limitations established by the federal statute. Funding is joint, and the quid pro quo for federal financial support is the willingness of states to conform their programs to the standards of the federal statute and regulations. This is the sense in which this Court has described these programs as exercises in "co-operative federalism." King v. Smith, 392 U.S. at 316; Harris v. McRae, 448 U.S. at 308.

The establishment of limits or standards applicable to state public assistance programs represents the

exercise of the federal spending power, for Congress may clearly "fix the terms on which it shall disburse federal money to the States." Pennhurst State School v. Halderman, 451 U.S. at 17. But unlike regulatory legislation, the relationship between federal and state governments under these titles is "in the nature of a contract." Id. In this context, the

> "legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.' ... There can ... be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it. Accordingly, if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." Id.

These principles are transgressed by the attempt here to withdraw federal funds previously paid to Connecticut on the ground that Middletown Haven was an IMD. The exclusion now asserted by the

Department was certainly not unambiguously imposed by Congress. As shown, the IMD clause embodies a far more limited Congressional purpose. Moreover, the Department's method for implementing its broader interpretation of the IMD clause, including reliance on subjective and confusing criteria of dubious validity, wholly failed to provide the prior notice that must be the predicate for the "knowing acceptance" required by Pennhurst for limits applicable to the grant of federal financial support. Cf. Commonwealth of Kentucky, Department of Education v. Secretary of Education, 717 F.2d 943 (6th Cir. 1983), cert. granted, 83 L.Ed.2d 26 (1984).

Public assistance in general, and Medicaid in particular, are among the largest categories of expenditures made

by states.[81] Further, Medicaid is bewildering in its complexity. It affords states scores of options for coverage and scope of services, each of which can have major budgetary implications.

If states elect to participate in the Medicaid program and receive the accompanying federal funds, only to find later that new limitations will be imposed after the fact, creating a large repayment burden that must be satisfied out of current funds, the impact on state treasuries and prudent fiscal management will be disastrous.[82]

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[81] In 1983 states (and local governments) spent almost $16 billion of their funds for Medicaid (DHHS Press Release, October 10, 1984), and an additional $6 billion for AFDC (Budget of the United States Government FY 1985, Appendix at I-K33).

[82] The importance to states of certainty in
(footnote cont'd)

The adverse affects of after-the-fact disallowances are not just budgetary and financial. The needy people served are also affected. No state can responsibly ignore federal attempts to disallow funds, even if not justified, and where states do respond by cutting back the challenged activity it is the needy recipients who will suffer most.[83]

(footnote cont'd)
federal standards and reliability of federal commitments is reflected in the Act. It explains why Congress provided for advance payment of the federal share, based on estimates, so that states would not have to finance the entire cost of covered services and rely solely on the promise of future reimbursement. See 42 U.S.C. §§603(b), 1396b(d). It also explains the provision that any sanction for state violation of its plan or of federal requirements be prospective only, and imposed only if the state fails to bring its operations into compliance. See 42 U.S.C. §§604, 1396c.

[83] Connecticut ceased claiming federal support for Middletown Haven after receipt of the disallowance in this case. See note 5, page 11, supra. Discharges from state mental hospitals to this and other nursing facilities were suspended after federal officials first raised the IMD issue in mid-1979. J.A. 7a.

These are some of the considerations that underlie the spending power standards enunciated in Pennhurst, which standards are not met by the Department's effort after the fact to disallow federal support for ICF services at Middletown Haven.

IV. DEFERENCE TO THE DHHS INTERPRETATION OF THE IMD EXCEPTION IS NOT JUSTIFIED.

A. The Department's Position Does Not Merit Deference Under the Applicable Precedents.

This Court has never accorded blind deference to administrative interpretations of Acts of Congress. As the Court reminded again just last Term:

> "Judicial deference to an agency's interpretation of a statute 'only sets "the framework for judicial analysis; it does not displace it."' ... United States v. Cartwright, 411 U.S. 546, 550 (1973).... A reviewing court 'must reject administrative constructions of [a] statute, whether reached by adjudication or by rulemaking, that are inconsistent with the statutory

> mandate or that frustrate the policy that Congress sought to implement.' Federal Election Comm'n v. Democratic Senatorial Campaign Comm., 454 U.S. 27, 32 (1981)." Security Industry Association v. Board of Governors 82 L.Ed.2d 107, 113 (1984).

This refusal to "rubber-stamp" administrative decisions that are "inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute" has been repeatedly emphasized. NLRB v. Brown, 380 U.S. 278, 291 (1965); Volkswagenwerk Aktiengesellschaft v. FMC, 390 U.S. 261, 272 (1968); SEC v. Sloan, 436 U.S. 103, 118 (1978); Federal Election Commission v. Democratic Senatorial Campaign Committee, 454 U.S. 27, 32 (1981).

Throughout this controversy, the Department has argued that its interpretation of the term "institution for mental diseases" should be upheld, and the disallowance sustained, based on the

deference that should be accorded an agency in the interpretation of statutes that it is responsible for implementing. No such deference is warranted here, because the Department's interpretation of the IMD exception does not comport with the terms, meaning or purpose of the Medicaid statute.

Even if the conflict between the statute and the current administrative interpretation were less clear, there would still be no warrant for the deference claimed by DHHS. This is not a case where the administrative construction has been clearly and consistently applied from the time the statute was first enacted. Compare Saxbe v. Bustos, 419 U.S. 65, 73-74 (1974). In the important early years of Medicaid, the Department viewed the IMD exception as limited to mental hospital settings. See pages

72-78, supra. When the Department did alter its official interpretation, it did so through internal memoranda, it let years pass before implementing its new view, and it provided states no means for sensibly predicting how the new interpretation would be applied. These factors all diminish any deference that the Department's interpretation might otherwise command. See Security Industry Association v. Board of Governors, 82 L. Ed. 2d at 114; Batterton v. Francis, 432 U.S. 416, 424-26 and n.9 (1977).[44]

Finally, the federalism interests involved, and particularly the powerful rationale for insisting on clarity in the terms of the governmental compact and

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[44] Also pertinent is the absence in the statute of a particular delegation of authority to the Department to interpret the IMD exclusion. Compare Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. at 43-44.

resisting after-the-fact imposition of conditions, militate against giving deference to the views of the Department, particularly when both partners are equally capable of understanding and construing the statutory terms.

B. The Department's Interpretation Is Premised on Policy Grounds That Are In Conflict With the Policy Adopted By Congress.

There are additional reasons for refusing deference to the Department's views. The express motivation for the Department's interpretation of the IMD exclusion as encompassing SNFs and ICFs is to respond to the transfer of patients from mental hospitals to nursing facilities. Pet. App. 15d.[85] The first of the

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[85] This concern about transfer of patients from mental hospitals into nursing homes seems to have been a prime impetus for the audit in Connecticut that resulted in the present disallowance. The audit report refers to "recent indications that (footnote cont'd)

internal memoranda that enunciated the Department's broadened view of the IMD exclusion stated that any facilities that concentrate "on managing patients with behavior or functional disorders and are used largely as an alternative care facility for mental hospitals" must be classified as IMDs. J.A. 2d.[86]

The notion that use of a nursing facility as an alternative to a mental hospital makes that facility an IMD is in square conflict with the statute and its underlying purposes, as shown above.

(footnote cont'd)
the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and intermediate care facilities (ICF's)" that caused the Regional Medicaid Director to undertake the investigation. J.A. 6a.

[86] The initial memorandum further asserted that any facility "frequently or predominantly used for individuals who are either discharged from mental hospitals or would otherwise be admitted to them are almost certainly in this [IMD] category ...." J.A. 2d.

Any suggestion that nursing facilities must be classified as IMDs to prevent inappropriate transfer of patients from mental hospitals (where Medicaid support is concededly unavailable for persons between the ages of 21 and 65) would also be contrary to Congressional policy. This is best evidenced by the provision of the Long Amendment that enjoins states adopting policies of moving patients out of mental hospitals and into other settings to provide "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." 42 U.S.C. §1396a(a)(20).[17] Enforcement of the obligation to readmit patients to the mental hospital is

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[17] The committee reports stressed the importance of this provision because "not always does a discharge plan work out to the best advantage of the patient." 1965 S. Rep. 145; 1965 H. Rep. 127-28.

furthered by the requirement of periodic professional review of the placement of and services furnished to residents of SNFs and ICFs. 42 U.S.C. §1396a(a)(26) and (33).

As these various statutory provisions demonstrate, Congress resolved the problem of "inappropriate" transfer of patients from mental hospitals to other facilities by providing for individualized periodic review of each recipient's situation and assurance of return to the hospital where needed, not by a blanket prohibition of Medicaid coverage for the alternate care facility that the Department opted for in its subsequent interpretation.[18]

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[18] Middletown Haven did not serve severe mental cases -- those with diagnoses of "acute mental disorder" (J.A. 43a), and a substantial number of residents that were admitted from state mental

(footnote cont'd)

When Congress has chosen a particular approach to the resolution of an issue, deference is not afforded to an administrative interpretation that incorporates a different, inconsistent approach. Security Industry Association v. Board of Governors, 82 L.Ed. 2d at 120.[88]

The Department's policy interpretation conflicts with Congressional policy in other respects as well. The DHHS approach, of disqualifying a facility based on the mental diagnoses of a majority of the residents, conflicts with the statu-

(footnote cont'd)
hospitals were returned to the hospitals for further treatment. J.A. 17a-18a.

[88] There is no evidence that the individualized policy selected by Congress has not worked, and ample evidence that it has succeeded. See 1971-72 Senate Hgs. 925-28. The mere fact of significant numbers of transfers from mental hospitals to alternative facilities does not, contrary to the Department's apparent approach, reveal a problem. That is exactly the result hoped for by the Joint Commission, and by the Congress when it adopted the Long Amendment.

tory policy against discrimination in the administration of the Medicaid program on the basis of diagnosis, a policy that finds specific expression in the regulations. See 42 U.S.C. §1396a(a)(10) and 42 C.F.R. §440.230(c) (1983).[89] The Department's position also has the effect of denying federal support to residents of nursing facilities who are not afflicted with mental disorders, if they happen to be residing in a facility that is categorized as an IMD based on the Department's view of its "overall

[89] The Eighth Circuit Court pointed to this unwanted feature in rejecting the Department's position. Pet. App. 21e. That court also found this feature to be inconsistent with the prohibition on discrimination on the basis of handicap, proscribed by the Rehabilitation Act of 1973, 29 U.S.C. §794, noting that "handicap" has been defined to include any mental disorder. 45 C.F.R. §§84.3(j), 84.4(b) (1983). See Pet. App. 21e, n.23.

character."[91] And for all people under age 65, the Department's position is at odds with the goal of the Joint Commission and the Long Amendment of reducing reliance on large mental hospitals.

A policy interpretation with these characteristics commands neither support nor sympathy, and since it is not compelled by clear and specific statutory terms, the regressive policy consequences provide still further reason not to accord any deference to it.

CONCLUSION

For all of the foregoing reasons, Petitioner respectfully requests that the Court reverse the judgment of the Court

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[91] The position has the further consequence that children may receive Medicaid support for care in expensive psychiatric hospitals (see note 36, page 48, supra) but not if their conditions are susceptible to treatment in less expensive alternative facilities that the Department decides are IMDs.

of Appeals and remand the case with instructions to have the disallowance in issue set aside, so that the federal Medicaid funds previously paid to support the services provided in Middletown Haven will be restored to the State of Connecticut.

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APPENDIX

APPENDIX A

FULL TEXT OF STATUTORY PROVISIONS INVOLVED

The following are provisions of the Social Security Act, Title XIX (Grants to States for Medical Assistance Programs), Pub. L. No. 89-97, § 121, 79 Stat. 343-353 (1965) (as amended) applicable to this controversy:

1. Section 1905(a) of the Act, 42 U.S.C. § 1396d(a)(1), (4)(A), (14), (15) and (18)(B), as amended, provides in relevant part:

> "(a) The term 'medical assistance' means payment of part or all of the cost of the following care and services . . .
>
> "(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
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> * * *
>
> "(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental

diseases) for individuals 21 years of age or older; . . .

* * *

"(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

"(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined . . . to be in need of such care;

* * *

"(18) . . .; except as otherwise provided in paragraph (16), such term does not include . . . (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases."

2. Section 1905(c) of the Act, 42 U.S.C. § 1396d(c), as amended, provides in pertinent part:

"(c) For purposes of this subchapter the term 'intermediate care facility' means an institution which (1) is licensed under State law to provide, on a regular basis, health-related

care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities . . .. The term 'intermediate care facility' also includes any skilled nursing facility or hospital which meets the requirements of the preceding sentence. . . . With respect to services furnished to individuals under age 65, the term 'intermediate care facility' shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects."[1]

3. Section 1902(a) of the Act, 42 U.S.C. § 1396a(20) and (21), provides in relevant part:

"A State plan for medical assistance must --

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[1] The provisions with respect to intermediate care facilities were added by section 4(a) of the Social Security Amendments of 1971, Pub. L. No. 92-223, 85 Stat. 809.

"(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases --

"(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

"(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution; and

"(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) of this title, section 803(a)(1)(A)(i) and (ii) of this title, or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

"(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;"

APPENDIX B

Excerpts from S.Rep. No. 404, Pt. I,
89th Cong., 1st Sess. (1965)

[p. 20]

2. Tubercular and Mental Patients

The House bill removed the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for combined program, title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. The House bill requires as a condition of Federal participation in such payments to, or for, patients in mental and tuberculosis hospitals certain agreements and arrangements to assure that better care results from the additional Federal money. The committee has amended this provision so as to make the special provisions for Federal participation applicable solely to payments for the aged persons in mental institutions. The States will receive additional Federal funds under this provision only to the extent they increase their expenditures for mental health purposes under public health and public welfare programs. The bill also removes restrictions as to Federal matching for needy blind and disabled who are tubercular or psychotic and are in general medical institutions.

Effective January 1, 1966. Cost: About $75 million a year.

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[pp. 144-47]

2. REMOVAL OF LIMITATIONS ON FEDERAL PARTICIPATION IN ASSISTANCE TO AGED INDIVIDUALS WITH TUBERCULOSIS OR MENTAL DISEASES

Since the enactment of the Social Security Act, patients in public mental and tuberculosis hospitals have not been eligible under the public assistance titles of the Social Security Act, and only prior to 1951 were individuals eligible who were patients in private mental and tuberculosis hospitals. The reason for this exclusion was that long-term care in such hospitals had traditionally been accepted as a responsibility of the States.

There have been many encouraging developments, in the meantime, in the care and treatment of the mentally ill and tuberculous. Most significantly progress is being made in the provision of short-term therapy in the patient's own home, in special sections of general hospitals, in specialized mental hospitals, and in community mental health centers. This latter type of facility is being particularly encouraged by Federal help under the Community Mental Health Centers Act of 1963.

For these reasons in reporting the social security bill (H.R. 11865) last

year, the committee added a provision, similar to the provision in this year's bill, which removes the distinction hitherto maintained in the public assistance titles of the Social Security Act -- between the aged who are ill with a diagnosis of psychosis or tuberculosis and the aged with other diagnosed illnesses.

Under the provisions of the committee bill, Federal financial participation would become available effective January 1, 1966, in assistance (money payments, if appropriate, or payment for medical care) for aged persons otherwise eligible under State plans for OAA, MAA, or under the combined programs for the aged, blind or disabled (title XVI) who: (1) are patients in hospitals for mental diseases or for tuberculosis or (2) are patients in general hospitals without regard to the length of their stay, and are there because of a diagnosis of psychosis or tuberculosis. Federal financial participation would also become available for assistance under titles X, XIV, and XVI of the Social Security Act for blind or disabled persons of any age who are in a general hospital with a diagnosis of psychosis or tuberculosis.

Since the provisions of the bill are designed to improve the care provided by States and to assure that Federal participation is used for such improvement, it is not intended that the availability of care for the mentally ill or tubercular under other State or local programs be considered a resource in determining the

eligibility of patients for public assistance with Federal participation in the payments made.

The House bill incorporated special standards of care for mental and tuberculous patients. The Department of Health, Education, and Welfare has informed the committee that the number of aged tuberculous patients is so small that, with present methods of treatment, special safeguards are not necessary for this group. A committee amendment would accordingly leave the safeguards fully applicable to the mentally ill but would eliminate the special requirements for treatment of aged persons with tuberculosis who are in specialized institutions. A description of the safeguards follows:

For those States that wish to take advantage of Federal participation in payments to the mentally ill who are in institutions for mental disease, the bill requires a provision for a joint agreement or other arrangement between the units of State or (where appropriate) local governments, and where appropriate with institutions for mental diseases. This agreement is not only intended to set forth the way of work between the agencies administering welfare and health programs, but also to set forth alternative methods of care, particularly for the aged who are mentally ill. Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the aged who have mental problems. It is expected that the joint agreements will include

plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the aged who are considered able to care for themselves, under some form of protective arrangements. The committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus the committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for the aged person who had been placed under an alternate plan of care. Inasmuch as the public welfare agency will be responsible for the determination of eligibility under the State plan for all applicants for assistance in the hospital, it is important that representatives of the agency have free access to the patient in the hospital. It is equally important that the hospital give to the public welfare agency the information it needs to administer its part of the program including the provision of assistance and the related social services. Under the committee bill, the agreement must include these arrangements.

A second safeguard, under the committee's bill, is a provision that the State plan include a provision for an individual plan for each patient in the mental hospital to assure that the care provided to him is in his best interests and that there will be initial and periodic review

of his medical and other needs. The committee is particularly concerned that the patient receive care and treatment designed to meet his particular needs. Thus, under the committee bill, the State plan would also need to assure that the medical care needed by the patient will be provided him and that other needs considered essential will be met and that there will be periodic redetermination of the need for the individual to be in the hospital.

The committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provision for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 Public Welfare Amendments, State public welfare agencies are encouraged to provide social services for the aged and additional Federal financing is available to assist in the cost. Under the committee bill, these social services would be made available, as appropriate, for the aged who are in the hospitals or who would otherwise need care in an institution.

The committee believes that responsibility for the treatment of persons in mental hospitals -- whether or not they be assistance recipients -- is that of the mental health agency of the State. Social services may be needed for members

of the patient's family, and this responsibility can be carried by the local welfare agency with Federal financial help. When the patient leaves the mental hospital to receive one of the alternative methods of care, followup social services are usually essential if the discharge plan is to be successful. Such services can be given by the public welfare agency or (if provided in the agreement between the two agencies referred to earlier) could be given by the staff of the hospital. Social services to the aged who have mental health problems, the committee believes, are important as a means of preventing further deterioration and avoiding or delaying admittance or readmittance to the institution.

The committee recognizes that the administration of these provisions will place new responsibilities upon the welfare agencies and if these responsibilities are to be carried out effectively, appropriate planning and execution will be required. Thus the committee's bill provides authority for the Secretary to establish necessary methods of administration for the States in carrying out these provisions.

Under the bill, the Federal Government will be participating in the costs of care given to the needy aged in certain institutions. In order to assure that the rates for the care of recipients who are patients in such institutions are reasonable, the bill provides that the State must have suitable methods for the determination of the cost. The committee expects that this determination will be

made without imposing burdensome fiscal methods on the States.

The committee believes it is important that States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963. In order to make certain that the planning required by the committee's bill will become a part of the overall State mental health planning under the Community Mental Health Centers Act of 1963, the committee's bill makes the approvability of a State's plan for assistance for aged individuals in mental hospitals dependent upon a showing of satisfactory progress toward developing and implementing a comprehensive mental health program -- including utilization of community mental health centers, nursing homes, and other alternative forms of care.

The committee wishes to insure that the additional Federal funds to be made available to the States under the provisions of the bill will assist the overall improvement of mental health services in the State. State and local funds now being used for institutional care of the aged will be released as a result of the bill, but there is great need for increased professional services in hospitals and for development of alternate methods of care outside the hospitals. To accomplish this, States may have to reallocate their expenditures for mental health to promote new methods of treatment and care. The committee bill provides that the States will receive additional Federal funds only to the extent

that a showing is made to the satisfaction of the Secretary that total expenditures of the States or its political subdivisions from their own funds for mental health services are increased. Such expenditures may be financed under State or local public health or public welfare programs. Expenditures will be measured against a base period and will include comparable items of expenditure for mental health programs by States and local public health and welfare agencies, including expenditures for payments to or in behalf of public assistance recipients with mental health problems and expenditures for services and other administrative items under health and welfare programs.

APPENDIX C

Excerpts from Department of Health, Education, and Welfare, SSA, Office of Research and Statistics: Financing Mental Health Care Under Medicare and Medicaid (Research Report No. 37) (1971)

[pp. 36-38]

OTHER ISSUES

COMPREHENSIVE MENTAL HEALTH SERVICES

Medicaid provides Federal financial support for most psychiatric services for eligible persons of all ages, except in the case of the specific statutory exclusion of payment for care of patients under the age of 65 in mental institutions. Services important in the treatment of the mentally ill covered under Medicaid are:

(a) Inpatient hospital services -- hospitalization in psychiatric wards of general hospitals.

(b) Outpatient hospital services -- treatment in mental hygiene outpatient clinics, including community health centers, operated by qualified general and psychiatric hospitals.

(c) Physicians' services -- diagnosis, evaluation, and treatment by psychiatrists.

(d) Skilled nursing home services -- a required service for needy persons over age 21; optional for those under age 21.

(e) Other laboratory and X-ray services.

(f) Clinic services -- currently an optional service adopted by 30 States and the District of Columbia; these would include "free standing" mental hygiene clinics and community mental health centers.

(g) Prescribed drugs -- currently a State option covering medications such as psychotropic drugs.

The first five services listed are required by law for the categorically needy in a State Title XIX plan.

Although the above services are available under Medicaid for treatment of the mentally ill, administrative restrictions on services may be and have been set by the States, for example, limiting inpatient hospital care to 21 days. States are not permitted, under Title XIX, to differentiate or exclude services to persons on the basis of diagnosis; nevertheless, they may limit the amount of services provided, e.g., limiting physicians' services to one visit per month. In fact, HEW staff have observed during field visits that some States, in practice, limit psychiatric services even more than specified in their Title XIX plans. For example, States are expected to publicize eligibility requirements and

services available under Medicaid, yet this has been done on a limited scale only in some States; a number of States also restrict the amount of payments made for hospital outpatient treatment for the mentally ill, or for their treatment in general hospitals; and with the exception of a few of the larger States, utilization of the Medicaid program for community mental health services has been minimal.[**]

In regard to psychiatric clinic services under Medicaid, coverage may occur under the following conditions:

(a) If a clinic is part of an accredited general or psychiatric hospital, it is classified as providing outpatient hospital services, and coverage is required for the categorically needy under the law.

(b) If a clinic is not part of an accredited hospital, it may be covered

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[**] Publicity within a broad State educational and information program under Medicaid, is recommended as a requirement in the Report of the Task Force on Medicaid and Related Programs, op. cit., p. 74. However, the Task Force recommendation is broadly written, without specific reference to mental health programs. Unless this emphasis is reflected in such a requirement, it is probable that those jurisdictions which, in the past, have not encouraged utilization of mental health services will continue to understress this area in the future.

under clinical services which are currently optional under Medicaid.

There are no national data on utilization by the States of Title XIX funds for support of the community mental health services, although it is known that only 30 States and the District of Columbia have taken advantage of the option to provide clinic services, as indicated in table 27. The potential for use of community mental health services as an alternative to hospital inpatient care is suggested by the experience of one State where Medicaid payments for persons under treatment in community mental health centers have accounted for 5 to 60 percent of the income of individual centers in the State. Indeed, the Task Force on Medicaid and Related Programs recognized the general need for broadening the availability of services in State Medicaid programs, recommending that:

> Innovative facilities for provision of medical care (e.g., neighborhood health centers, community health centers, group practices, outpatient services of hospitals which provide neighborhood, comprehensive ambulatory care and other facilities) should be included as eligible vendors which recipients under Title XIX may elect and be encouraged to use, assuming appropriate standards of health care are met.[45]

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[45] Ibid., page 22.

However, a comprehensive program of services for the mentally ill, with emphasis on ambulatory care, at present is not a requirement under Medicaid, and is not included in the Medicaid plans of a number of States.

[pp. 39-40]

INPATIENT CARE IN PSYCHIATRIC HOSPITALS

Federal sharing with the States is available for the cost of most types of care for the mentally ill because Title XIX prohibits elimination of patients from the program on the basis of diagnosis.

In regard to those 65 years and over, data for fiscal years 1966, 1967, and 1968 on resident population and first admissions in public mental hospitals for the Nation and for the 10 States with the largest number of Medicaid patients in 1968, are given in table 30. The rate of resident aged patients in the country as a whole declined some 14 percent between 1966-68, and 8 percent in the first admissions during this interval. Seven of the States show a consistently higher rate of resident aged patients than the national average; 5 States had a higher rate of first admission. Of the 10 States cited, 8 had reduced rates of resident patients in 1966-67; all 10 States experienced such a decline in 1967-68. Rate of first admissions, however, although manifesting a similar trend in 1966-67, increased substantially

during 1967-68 in Massachusetts, Maryland, and New York.

The extent to which the availability of medical assistance payments has influenced the general drop in the number of resident patients and first admissions in public mental hospitals is not clear. Reports from States do indicate, however, the following gains resulting from Medicaid vendor payments and related requirements:

(a) increased medical treatment, surgical procedures, and prosthetic devices available to patients;

(b) increased use of alternatives to psychiatric hospitals;

(c) opportunities for patients to have comfort items, to purchase clothing for selves, etc., as a result of assistance payment allowances;

(d) increased use of social services, activities, and ward personnel; and

(e) more consistent checking of patient status and therapeutic needs.

AGE RESTRICTIONS ON INPATIENT CARE

As already noted, a major benefit of Medicaid is coverage of eligible persons aged 65 and over for inpatient care in psychiatric institutions. But, it is clear that a major limitation of Title XIX is the exclusion of persons under age 65, from like inpatient services in a

psychiatric institution. There are, indeed, two major exclusions:

(1) inpatient hospital services for mental diseases are prohibited for all persons under age 65; and

(2) skilled nursing home services for mental diseases are prohibited for all persons under age 65.

It may be noted that adults aged 18-64, in order to be eligible for inpatient care in psychiatric institutions under Title XIX, would have to meet State definitions of permanent and total disability. The definition of permanent and total disability varies considerably among the States. Taking these factors into consideration, a rough estimate of the daily census of adults under age 65 in mental hospitals who might be covered under Medicaid at present in the category of permanent and total disability, is 75,000; an additional smaller number probably could also qualify under the Aid to the Blind program. Dr. Leonard Ganser, a psychiatrist speaking for the National Association of State Mental Health Program Directors, in 1967, estimated a total of some 253,000 persons under age 65 would become eligible for benefits under Title XIX if they were hospitalized in a mental hospital, should the present age limitation be removed.**

** Hearings Before the Committee on Finance, U.S. Senate, 89th Congress, op. cit., Part 3, p. 1745.

As noted previously, the National Institute of Mental Health has projected resident populations in mental hospitals by age from 1967 through 1973. The expected changes by 1973 are summarized in chart 5. Most striking is the substantial decline in hospital patients anticipated at every age group except under 25 years, which shows an increase of 7 percent. Indeed, rates of admission to public mental hospitals of young people have shown an alarming increase over the years despite the development of community resources. There can be little doubt that a large percentage of the 34,376 young people expected to be in public mental hospitals by 1973 would be eligible for assistance from the Medicaid program if the present age restriction were lifted.

No data are available on the likely cost to the Federal government if inpatient psychiatric treatment was included in Medicaid benefits to persons 18-64 years old. In this regard, however, psychiatric experts consulted by DHEW staff stressed two factors:

(1) The age restriction in Title XIX excluded people in age groups most likely to benefit from active treatment in the psychiatric hospital.

(2) Such treatment made available under Medicaid would contribute to the rehabilitation of young and middle-aged adults and facilitate their return to the community as economically productive and useful members of society.

[pp. 47, 48-49]

Appendix 1

LEGISLATIVE HISTORY OF FEDERAL FINANCING OF PSYCHIATRIC SERVICES

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B. MEDICAID--TITLE XIX OF THE SOCIAL SECURITY ACT

Under the original Social Security Act in 1935, patients in public mental and tuberculosis hospitals and inmates of State institutions for the mentally retarded were not eligible for public assistance because care of the mentally ill traditionally was considered a responsibility of the States. And in 1950, when Federal financial participation became available for medical care of public assistance recipients, the decision was made not to include patients in mental hospitals, because the legislators felt the best way to get assistance to the States in this area was via a broad grant program, not through aid to the individual. This change also prohibited the use of Federal funds for care of patients in general hospitals with a diagnosis of psychotic condition, which prevented States from transferring mental patients to general hospitals just to get Federal money.

But in 1960, the long-held policy of prohibiting Federal financial assistance

for the care of patients in mental hospitals began to relax partly because of the recognition that new treatment methods made possible the care of mental patients on a short-term basis.

In 1960, Senator Russell Long first introduced an amendment to permit Federal matching of vendor payment under Title I (Old Age Assistance) for public mental hopitals. While this particular measure failed to pass, medical payments for aged persons with a psychiatric diagnosis were permitted for up to 42 days when such persons were being treated in general hospitals.

In June of 1962, the Department of Health, Education and Welfare's Bureau of Family Services changed its policy regarding public assistance payments to patients on convalescent leave from mental hospitals to permit States to obtain matching Federal funds in this area. Any State that wished to take advantage of such Federal matching funds was required to make provisions for an agreement between its public assistnace agency and the agency responsible for institutional care of the mentally ill.[1]

Provisions similar to those introduced by Senator Long in 1960 were incorporated in the 1964 Social Security bill (H.R. 11865). Although this bill too failed to

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[1] This was a direct forerunner of the provision for such written agreements found in the 1965 Welfare Amendments to the Social Security Act.

pass, the so-called "Long Amendments" were included in the Social Security bill of 1965, ultimately passed as P.L. 89-97--the Social Security Amendments of 1965. This established, in addition to Title XVIII (Medicare) discussed earlier, Title XIX (Medicaid) of the Social Security Act, which contained medical assistance to aged individuals, including coverage for those patients in institutions for the treatment of mental diseases who meet State standards of financial need.

The mental health provisions of Title XIX made Federal financial participation available, effective January 1, 1966, for persons aged 65 and over who were eligible for Old Age Assistance or Medical Assistance to the Aged, or under the combined adult assitance programs (Title XVI). Included were the elderly in hospitals for mental diseases (or for tuberculosis) or in general hospitals because of such diagnosis, regardless of their length of stay. Title XIX also removed the earlier 42-day limitation, and provided for Federal assistance to eligible persons of any age under OAA, MAA, AFDC, AB, and AFTD who were hospitalized for mental illness in general hospitals.[1]

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[1] OAA - Old-Age Assistance
MAA - Medical Assistance to the Aged
AFDC - Aid to Families with Dependent Children
AB - Aid to the Blind
APTD - Aid to the Permanently and Totally Disabled

The Long Amendment is a companion piece to the Title XVIII legislation that makes Federal assistance available for eligible aged persons in mental institutions, when Medicare benefits have been exhausted.